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ABSTRACT

In order to lay the foundation for the development of an agenda for health services research among Hispanics for the 1980's and beyond, over 200 conference participants drawn from among Hispanic and non-Hispanic health service researchers, health providers, users of research data, health science students, consumers, and representatives of Mexico's Ministry of Health addressed health problems of U.S. Hispanics, identified needed areas of research, and recommended methods of conducting health research among Hispanic populations. Following initial addresses regarding Chicano culture, accountability in Hispanic health services research, and the development of the agenda, participants divided into four task forces to hear and discuss solicited papers and make recommendations. Task force one focused on the impact of national, regional, state, and local policies regarding health services for Hispanics, and recommended research topics in the areas of policy formation, program implementation, and program evaluation. Task force two studied sociocultural influences on health services research and delivery for Hispanics. Task force three focused on resource development strategies for conducting health services research among Hispanic populations. Its recommendations addressed language use, research tools, health science education curricula, and intervention in specific diseases. Task force four studied the facilitation of timely dissemination, assessment, and use of Hispanic health services research. (Author/SB)

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Hispanic Health Services Research

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Abstract

This report contains the proceedings of the first Hispanic Health Services Research Conference, which was supported by a grant from the National Center for Health Services Research with additional funding from the Veterans Administration. The Conference addressed the health problems of Hispanic populations in the U.S., identified needed areas of research, and recommended methodologies appropriate for conducting health research among Hispanic populations. The recommendations of the Conference are presented in the individual reports of the four task forces, which focused on: the impact of national, regional, state and local health policies on health services for Hispanics; sociocultural influences and health services delivery for Hispanics; resource development strategies for conducting health services research among Hispanic populations; and facilitation of the timely dissemination and assessment of Hispanic health services research.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Services Research
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September 1980

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Foreword

The National Center for Health Services Research (NCHSR) is the principal source of federal support for general research on problems related to the quality and delivery of health care services. NCHSR is authorized to undertake a broad range of research, demonstration, and evaluation activities encompassing virtually all aspects of health services delivery in this country. NCHSR has made a concerted effort to assure that its resources support research activities that are of potentially high social utility.

Demographers predict that the Hispanic population will soon be the largest minority in the United States. Because there is a great deal to be learned about the organization and delivery of health care services to the Hispanic population of this country, the University of California, Los Angeles, School of Public Health, with support from NCHSR and the Veterans Administration, organized and conducted the first conference on Hispanic health services research in Albuquerque, New Mexico, September 5 to 7, 1979.

The purpose of the conference was to lay the foundation for the development of an agenda in health services research for Hispanics for the decade of the 1980s and beyond. Conference participants were drawn from among Hispanic and non-Hispanic health services researchers, health providers, users of research data, health science students, and consumers. Representatives from Mexico's Ministry of Health also attended.

In sponsoring this conference on Hispanic health services research, the UCLA School of Public Health took an important step toward addressing the critical problem of data needs and other health services research issues regarding health and illness among Hispanics. How research findings can be used to relieve pressing health problems was another element of the conference.

The substantive discussions which took place among conferees will undoubtedly prove to be most valuable and productive. We look forward to the continued development of Hispanic health services research and to collaborative health services research efforts in the future.

Gerald Rosenthal, Ph.D.
Director
National Center for Health
Services Research

Lester Breslow, M.D., M.P.H.
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University of California,
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Introduction

The first Hispanic Health Services Research Conference (HHSRC) developed from a series of small interregional health meetings for Hispanics held throughout the United States in 1976. The idea for such a conference was pursued by Dr. Jaime Salazar and encouraged by Mr. Joseph de la Puente and Dr. Carl Hopkins. Dr. Salazar developed an unsolicited proposal for the conference and submitted it to the National Center for Health Services Research for funding consideration. The grant was approved, and funds were awarded to the University of California, Los Angeles, School of Public Health—the sponsor of the conference. Additional support was given by the Veterans Administration. The planning and implementation of the HHSR conference benefited greatly from the contribution and guidance of the following members of the Conference Organizing Committee, four of whom also served as task force leaders:

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Background

The first Hispanic Health Services Conference, sponsored by the National Center for Health Services Research with additional funding from the Veterans Administration, was held September 5 to 7, 1979, in Albuquerque, New Mexico. The HHSRC was convened as a result of recommendations made at several interregional meetings of Hispanic health services researchers and consumers. These meetings took place in selected metropolitan areas of the U.S. during 1976: Washington, D.C.; Chicago; New York; Seattle; Los Angeles; San Antonio; Miami; and San Juan, Puerto Rico. The participants at these meetings identified and discussed health services delivery problems affecting the Hispanic population in their respective areas and concluded by making recommendations.

A common problem identified at the meetings was the paucity of hard data regarding the Hispanic population. The participants at the interregional meetings expressed the concern that most published information about the health and illness attitudes and behavior of Hispanics was anecdotal, romanticized and not based on scientifically collected data. Moreover, the participants noted that the literature and statistics compiled by the federal government on Hispanics and health also revealed a lack of scientific data. A repeatedly stated concern was that attempts by the federal government to address the health problems of the Hispanic community often failed because they were not based on scientific data accurately reflecting the health status and needs of the Hispanic population. These area meetings focused on this lack of scientific data and recommendations for resolving the problem:

1. A minimum of two Hispanic health services research centers should be established: one to serve the Hispanic population of the eastern United States and the other to serve the population west of the Mississippi. These centers would be responsible for collecting scientific health data regarding Hispanics. They would also function as resource centers providing technical assistance, training and support to individuals conducting health-related work in the Hispanic community.

2. Hispanic and non-Hispanic health services researchers should be encouraged to conduct research studies focusing on Hispanics.

3. Health professional schools, especially schools of public health, should be strongly encouraged to recruit Hispanic students and to provide them extensive training in research methods.

4. Hispanic health services researchers in the U.S. should develop working relationships with their counterparts in Latin American countries.

5. Finally, it was recommended that a conference be convened where health services researchers, health providers, consumers, students, and others would come together to develop a practical and coordinated health services research agenda for Hispanics.

This final recommendation led to convening the Hispanic Health Services Research Conference.

Goal and objectives

The goal of the Hispanic Health Services Research Conference was to plan a practical health services research agenda for Hispanics for the 1980s and beyond. Objectives of the conference were:

1. To provide an environment for the interchange of ideas concerning appropriate health services research methods to be used in the Hispanic community.

2. To produce greater awareness among Hispanics and other health professionals about Hispanic health services research needs through presentations and discussions in workshop settings.

3. To introduce conference participants to federal representatives and others whose agencies are responsible for supporting health services research activities and collection of health statistics.

4. To foster cooperation of federal and nonfederal agency representatives with Hispanic and non-Hispanic health professionals working with Hispanic populations.

5. To stimulate involvement in Hispanic health services research having practical application as well as theoretical value.

6. To review legislation and regulations which impact on the delivery of health services to Hispanics.

7. To identify areas for Hispanic health services research and prioritize those areas for funding.

8. To establish a network of Hispanic and non-Hispanic health services researchers and users of research.

9. To communicate the results, recommendations and implications of the HHSRC to: (a) health workers concerned with Hispanic health issues, (b) governmental agencies, and (c) potential users of the conference results.

10. To plan future activities in Hispanic health services research, by (a) establishing a national clearinghouse of Hispanic health; (b) considering the formation of an academy of Hispanic health services researchers; and (c) arranging for periodic conferences on Hispanic health services research.

Conference format

A briefing meeting attended by the Organizing Committee members, recorders, conference staff, the project officer, and the project director was held on the day preceeding the formal conference. Working assignments were reviewed and conference details finalized. A press conference with local news media representatives followed the briefing meeting.

To welcome conference participants, a social hour and banquet were held where Archbishop Robert F. Sanchez from the Archdiocese of Santa Fe gave the invocation. Following dinner, author and lecturer, Dr. Sabine Ulibarri, spoke about Hispanic cultural awareness. The evening concluded with entertainment provided by the Miguel Caro Dancers, a group of Mexican-Americans who performed dances representing the different regions of Mexico.

The HHSR Conference was convened at 8:30 a.m. on September 6, 1979. New Mexico's Lieutenant Governor Roberto Mondragon, along with Dr. William Davis, president of the University of New Mexico, gave welcoming addresses. Dr. Lester Breslow, dean of the School of Public Health at the University of California, Los Angeles, then discussed issues of Hispanic health. He was followed by Ruth Hanft, deputy assistant secretary for Health Research, Statistics, and Technology, who provided conference participants with an overview of her responsibilities with the Department of Health, Education and Welfare, now the Department of Health and Human Services. The Director of the National Center for Health Services Research, Dr. Gerald Rosenthal, then presented NCHSR perspectives. Joseph Birmingham, director of the Veterans Administration Medical Center in Albuqerque, gave a brief overview of the VA's efforts to provide services to Hispanic veterans. He was followed by Dorothy Rice, director of the National Center for Health Statistics, who discussed NCHS activities with respect to Hispanic health statistics and described the Health and Nutrition Examination Survey (HANES), which for the first time will include a special sample of Hispanics.

The first morning of the conference concluded with the featured speaker, Faustina Solis, discussing accountability in Hispanic health services research. She stated that too often researchers have romanticized Hispanic health and illness attitudes and behavior, much to the detriment of this population. She voiced other concerns regarding Hispanics and health services research:

1. The questionable reliability of interview instruments which are simply transiated from English to Spanish.
2. The lack of professional Hispanic health services researchers.
3. The lack of Hispanic health services research focusing on maternal and child health and adolescents.
4. The need for Hispanics working in the area of direct health and those in mental health to seek alliances. "Federal funding structures should not keep us apart," she stated.

During the luncheon, Dr. Carlos Vallbona, a member of the Organizing Committee, discussed the development of an Hispanic health services research agenda and concluded by giving the members of the four task forces their charges. The task forces then met separately where papers were presented, discussed, and recommendations made.

The final conference function of the first day was a special session held to discuss the U.S.-Mexico Border Health Agreement. Dr. Gerald Rosenthal, director of NCHSR, opened the meeting and discussed procedural issues. He then introduced Dr. Richard Coppedge, director of the Pan American Health Organization, who described the intent o. the Agreement and events leading up to its signing in April 1979. He emphasized the expansion of health services in relation to the International Year of the

Child, as well as issues of existing health resources. Following Dr. Coppedge's presentation, Dr. Manuel Ruiz de Chavez, Ministerio de Salud, Subsecretaria de Planeación, Mexico, D.F., was introduced. He discussed the problems of meeting the health needs of the population and stated that we must seek more efficient delivery of health services based on health services research. Dr. Ruiz de Chavez informed the group that Mexico is currently conducting a survey of health and medical care delivery services to the population of Mexico City. Ruth Hanft, Office of Health Research, Statistics, and Technology; Marlyn Kefauver, Office of International Health, Office of the Americas, Public Health Service; and Nancy Pearce, NCHS, discussed their agencies' objectives relative to the U.S.–Mexico Border Health Agreement. Dr. Rosenthal addressed the need for discreet research strategies and a timetable for implementing collaborative efforts with research teams on both sides of the border. Open discussion followed, and the meeting was adjourned.

On Friday, September 7, 1979, conference activities began with a special session sponsored by NCHS to discuss the Health and Nutrition Examination Survey (HANES). Ruth Hanft, Dorothy Rice, Bob Murphy and Kurt Maurer conducted the meeting attended by approximately 30 persons.

The morning general session began with the introduction of Dr. Manuel Ruiz de Chavez, Ministerio de Salud, Subsecretaria de Planeación, Mexico. Dr. Ruiz de Chavez gave a presentation in Spanish on "Research Issues in the Evaluation of Health Services." Dr. John Landsverk, University of California, Los Angeles, School of Public Health, then reported on the survey conducted by the project staff—"Hispanic Health Services Research Priorities"—and discussed the results and findings of that research. Overall, the results showed that a priority item in Hispanic health services research is the establishment of coordinated and collaborative mechanisms for conducting research. Dr. Carlos Vallbona then gave a report on the progress of the task forces, following which the task forces reconvened.

The conferees convened in an afternoon general session with Dr. Carl Hopkins, University of California, Los Angeles, School of Public Health, moderating the session. The four task force leaders presented the summaries, conclusions, and recommendations of each task force. Following the task force reports, the floor was opened to questions and further recommendations from the conferees.

The final session was a plenary session to discuss "Funding Considerations for Future Hispanic Health Services Research." Dr. Salazar moderated the session, which included: Dr. Richard Coppedge, Pan American Health Organization; Dr. Lionel Fernandez, Office of Health Resources Opportunity; Ruth Hanft, Office of the Deputy Assistant Secretary for Health Research, Statistics, and Technology; Dr. Richard Hough, Veterans Administration; Dorothy Rice, National Center for Health Statistics; Dr. Gerald Rosenthal, National Center for Health Services Research; and Lindsay Wagner, University of New Mexico, Research Administration.

The panelists gave brief explanations of their organizations' missions and funding priorities and then responded to questions from the floor. The conference concluded with brief closing remarks by the project director.

Introductory presentations

Ruth Hanft
Deputy Assistant Secretary for Health
Research, Statistics, and Technology

First, I'd like to bring you greetings from the Surgeon General and the Assistant Secretary for Health. He takes a great interest in the Department's efforts to develop the Hispanic Initiative which cuts across issues of health, social services and income maintenance. I hope in the near future there will be a major announcement about that initiative; Dr. Richmond has been personally interested in the issue of Hispanic health care and has personally worked on the Border Health Agreement with Mexico. I bring you his greetings. Regrettably, he was not able to join us.

Although its genesis really comes from many sources, this conference is part of that Hispanic Initiative. When my office was reponsible for the Health Policy Office for the Public Health Service, before one of the recent reorganizations of the PHS, it developed the Hispanic Initiative for PHS. As part of the initiative, we developed some programs in health services research and some work in health statistics that would be valuable in planning health services for the Hispanic population. This conference really pre-empts the announcement of the Hispanic Initiative because we did not want to wait—those initiatives take a long time to put in place.

You heard today that the Hispanic population constituted about 10 percent of the American population. Well, I have some slightly different projections, and those projections show that by about 1990, the Hispanic population of the U.S. will be about one-fifth or 20 percent of the population if census counts accurately this time, and if we can really get a good estimate of the undocumented population. It is a rapidly growing population—diverse in income, diverse in social background, and diverse in cultural background. I personally don't believe any one model or one solution will solve the problems of all Hispanic communities across the country. Some of the resolutions in the southwest may vary from the resolutions needed in New York and Chicago or in Miami. So I think when we talk about health services research and health statistics, we have to be a little more sophisticated than just calling it Hispanic data or Hispanic health services research. We have to get to a different level of aggregation and really get into the cultural and the social aspects of the particular, and to some extent, the local population. That presents great problems for statistics and research, which I know Dorothy and Gerry will explore with you a little more.

To address the health services issues of the population, it is very clear that we have to know more. While there have been a number of scattered studies and a number of very good studies, there hasn't been a systematic statistical or health services research agenda that we worked on over time. I hope this is just the first of a number of conferences on this issue and on the results of research and statistics that evolve from setting a research agenda.

Let me now turn for just a few minutes to the role of the Office of Health Research, Statistics, and Technology. It is the longest title in the Public Health Service for the smallest organization. We are the baby of the PHS, and we consist of three centers: The National Center for Health Statistics, which is the oldest of the centers; the National Center for Health Services Research, and finally a brand new center—the National Center for Health Care Technology. NCHSR, which Gerry Rosenthal heads, is the only general health services research organization at the federal level. All other health services research at the federal level is done as a part of a program and related to that specific program. For example, the Health Care Financing Administration conducts health services research related specifically to Medicare and Medicaid. We are the only center that has broad-based responsibility in all fields to address all issues of health services research. Regrettably, the budget

of our organization does not match its mandate, but we do the best we can, and we have developed a very sophisticated priority-setting program to decide where we should put our scarce dollars—and one of the places we put it was in this conference because we believed it was so important.

We believe very strongly in the importance of the role of health services research to identify problems; to provide information for alternative solutions; and then to evaluate what solutions we've come up with. We keep refining our methodology in health services delivery, in financing, in manpower, and all across the health services research field. We do this in a number of ways. We do it through intramural research conducted by our own staff, we do it with specific grant solicitations when we find an issue of interest and put out a grant solicitation or a request for proposals in that specific area. We also support some health services research centers around the country that, to a large extent, developed their own agendas and developed agendas important to their own particular region.

I do not want to say anything more about the National Center for Health Services Research because I know Gerry will do that. I just wanted to give you a flavor of where it fits into the health services research community, and that it is the only general purpose center there is in the U.S. at the federal level.

The National Center for Health Statistics is a very old organization. It also is the only general purpose health statistics organization at the federal level. All other statistical operations relate to specific programs like Medicare or Medicaid, or health manpower. The NCHS collects and analyzes statistics on health status, health resources, utilization and financing. Until recently separate data identifying the Hispanic population were not collected. The Hispanic population was included until very recently in the general white count of the population. We are now collecting data on Hispanics in a number of our surveys, and many of the states are now doing so in the vital statistics area. NCHS has a family of surveys that provide most of the data in the U.S. on the utilization of services, on the nutritional status and the health status of the population, and to some extent—we hope soon—on the expenditure for services. These surveys include the Health Interview Survey and the Health and Nutrition Examination Survey, which you will hear far more about because we have a major Hispanic initiative as part of that survey now. We also have a new survey called the National Medical Care Use and Expenditure Survey, as well as the Hospital Discharge Survey and the National Ambulatory Medical Care Survey. The Family Growth Survey gives us the basic data on fertility of the population, family planning and a number of other issues. The NCHS is also the sponsor of something called the Cooperative Health Statistics System. This is a federal-state partnership to collect statistics primarily in three areas: vital statistics, health manpower and health facilities. When these statistical systems are fully in place in all the states, they should be able to provide information for planning at the local level—particularly by HSAs, by community groups and others. They will tell you what is there, what the health status of the population is, what facilities exist and what manpower is available. The NCHS also provides considerable assistance to other agencies, including states, in terms of setting up statistical systems, collecting data and analyzing those data. Finally, we have just developed—and we are all very proud of it—something called the Death Index, which is going to help us enormously with epidemiologic studies in the future.

Finally, there is the National Center for Health Care Technology, which probably has less direct relevance to this conference at this

point in time, but not in the long run. It is the newest center. It was established in November by legislation because of the multiple concerns about safety, efficacy, cost, cost effectiveness, the social and ethical issues related to technology, both new and emerging technology and existing technology. In an era of scarce resources, the nation can no longer proliferate technologies that are either ineffective or whose costs do not produce a change in health status that is worth the cost. A lot of these are societal decisions, but there has been no systematic way until now to assess a technology in terms of its impact on the patients, its impact on the health care system, its access, its cost consequences and some of its ethical consequences. The new center is to coordinate the technology assessment activities with HEW. An example of an important technology that you will be reading about in the newspapers, I am sure within the next month, is on the issue of maternal serum alpha-beta protein. It not only involves the safety of a particular lab test, but it involves the proficiency of labs. It also involves a very complicated Medicaid issue: payment for an abortion where the fetus is diagnosed as having spina bifida. This is the kind of issue that the center will be dealing with. It will conduct assessments itself, and it will fund research in technology assessment. Finally, it will provide advice on coverage issues to Medicare and Medicaid and advice to Health Systems Agencies, State Health Planning and Development Agencies, and health planning organizations on the appropriate use of technology. It is already linked into the PSRO system in terms of appropriateness of use of certain technology. Although it will be small for the next few years, we expect that in about five years it may have considerable impact on use of resources in health care, the appropriate use of these resources, and on health status itself.

Dorothy Rice
Director, National Center for
Health Statistics

It is indeed a pleasure to be here, although difficult to follow my colleagues. They so adequately described the work of the National Center for Health Statistics and referred to all the activities we are involved in—the collection and dissemination of statistics on the health of the nation. I thought that it would be appropriate for me to lay out the problems that we have in collecting health statistics on the Hispanic population. We recognize that there is a lack of basic health information on this important population group. We face lots of problems but we have some solutions.

We have identified several gaps in health information on the Hispanic population group, and they are serious. I would just like to emphasize a few of those gaps. First, there are no basic mortality data to measure the health status of this group. Infant death, life expectancy, and causes of death for Hispanics have not been available in the national vital statistics data from NCHS. Secondly, data on morbidity among Hispanics are very sketchy. Our morbidity data are derived from population samples that frequently are too small for descriptions and analysis of the health status of the Hispanic population. Thirdly, there are little data on health care utilization and health care finances. We actually know so little about the Hispanic use of medical services, of hospitalization, dental care, or about their health insurance coverage and expenditures for medical care. Again, the national surveys just are not large enough without special emphasis on this population group.

How do we at the federal and NCHS levels try to respond to this problem? As you know, Congress, in the Roybal Act (P.L. 94-311), mandated the collection of social and economic data on Hispanics at the national level, and the NCHS was designated as the lead agency for the coordination of health statistics on Hispanics.

Secondly, federal statistical agencies such as the NCHS have been directed by the Office of Management and Budget (OMB) to follow a set of race and ethnic standards in their statistical activities, and you will be seeing the results of this very important effort.

The latest OMB standard for minimum acceptable race and ethnic categories for stastistical and administrative reporting was set forth in a circular that all of us know, A-46, later superceded by Directive No. 15 of the Office of Federal Statistical Policy and Standards. These issuances require that we be able, from our data collection programs, to identify five population categories. I know that this is not new to all of you, but let me just mention them: American Indian or Alaska native is one; Asian or Pacific Islander is second; black, not of Hispanic origin; then Hispanic; then white, not of Hispanic origin. Those are the categories that we are using in reporting data, where standards of reliability permit such breakdown. These categories are the basis for the production of data that heretofore have not been available for Hispanics.

We feel that we have a responsibility in this area. The NCHS response to the need for health statistics on the Hispanic population goes well beyond these OMB directives, and it addresses the major gaps in health information that we have already identified. Let me just mention a few of our activities.

In the vital statistics area, the national vital statistics are collected for NCHS by the states through their registration of births and deaths. A major problem is that because the birth and death certificates are under state auspices, Hispanic origin items are often omitted or not comparable from state to state. In addition, some states rely on Spanish surname lists instead of an item on ethnic origin.

Through our Cooperative Health Statistics System that Mrs. Hanft mentioned, NCHS has been promoting uniform and comparable vital statistics on Hispanics and inclusion of an His-

panic identifier on the certificates. The states have been responding. Most states with large Hispanic populations now have an item or, like New Mexico and Texas, are in the process of adding Hispanic origin items to their birth and death certificates. For the 1978 data year, it will be possible for us to code Hispanic origin from the birth certificates of 17 states and from the death certificates of 19 states. For 1980 data, the number of states will increase to 22 for births and 21 for deaths. This is quite an improvement over what we have had before—it is real progress toward complete national coverage. NCHS plans to publish these new data on Hispanics beginning with the 1978 data year, depending upon examination of the completeness and quality of the reporting.

In each of our several health surveys, we have made or will make an attempt to identify the Hispanic population. But again, these surveys are national probability samples, and usually the numbers of Hispanics falling in the sample are very, very small. Even though the Hispanic population is nearly six percent of the total U.S. population and going up, Hispanics are spread out over several areas so that it is difficult to put together a national probability sample in one survey. There are some exceptions. One is our National Survey of Family Growth, which in 1973 and again in 1976 could report data for Hispanics. Beginning in 1976 Hispanic identifiers were added to the race items on the questionnaire of the National Health Interview Survey. Beginning with 1978, separate questions were used for race and ethnicity conforming to the OMB standards on distinguishing black Hispanics from white Hispanics. These additions have produced valuable data, some of which are now in print, on the Hispanic population's use of health services and general health status, for example, our Advance Data note No. 27 on the health characteristics of minority groups in the U.S., including the Hispanic data for 1976. We will be producing additional data in the future. *Health U.S., 1979*, which is the annual report on the nation's health by the Secretary of HEW and the Assistant Secretary for Health to the Congress and to the people of the U.S., includes a chapter on minority health. It presents all the information we could get from various sources of data on Hispanics, and reprints are available.

Our most important activity—a special activity—is a very new one. Many of you know that one of our surveys is the National Health and Nutrition Examination Survey by which we actually go out and interview and examine a sample of the population. In the first HANES, from 1971 to 1974, the sample included only 1,400 persons of Spanish origin. Provisional findings are that the nutritional status of Hispanics is above established standards except for deficiencies in iron and Vitamin A intake for some subgroups when classified by age and sex. Dr. Breslow has summarized some of the information about the health status of the Hispanic population. It is clear that we need a lot more information. In our second HANES, which is nearing completion, as in the first, the sample numbers of Hispanics limit the reliability of the estimates of their nutritional and health status. In response to this, the Center has taken a creative and unusual approach by undertaking a special Health and Nutrition Examination Survey of Hispanics, and this is a very exciting activity. Before telling you about it, I should acknowledge a little push toward the Hispanic survey from a very illustrious group.

A couple of years ago, the NCHS contracted with the National Academy of Public Administration, the NAPA group, to evaluate the nutrition component of our HANES program. The panel consisted of a very capable group of people, including Dr. William Stewart, who is a former Assistant Secretary for Health and Surgeon General of the Public Health Service and now is with the Louisiana State University Medical Center. It also included Wilbur Cohen,

former Secretary of HEW who is now with the University of Michigan. They were the co-chairmen of the panel. This panel was charged with the responsibility of making recommendations to the Center concerning changes in the objectives or methods of the nutrition component of HANES that would render it more effective and useful. They haven't finished their work, but they have published an interim report recommending that we should begin to look at the health status of subpopulation groups, including the Hispanics, and suggesting that perhaps the examination of the Hispanic population would be the logical choice immediately after completion of the second HANES survey early in 1980. Some of you here will be hearing more about our studies and will, we hope, help us in the design and implementation of this very new and important initiative.

We do feel that the objectives of this new effort are very important. We expect to assess the health and nutritional status of the Hispanic population. We will be sampling the Hispanics in at least three different areas of the United States. We expect to look at a sample of the Hispanics in the Southwest, the Puerto Ricans in Puerto Rico and in New York City and, hopefully, the Cuban Americans in the Miami area. We will need a lot of help in the design of this survey, and we look forward to working with you on this survey that we expect to move forward in 1981. The fact is that we are here to listen. As our friend from the VA told us, we are here to learn more about how to approach this population group with its special cultural needs. This is an important forum for us. So I am pleased to join our colleagues here in hearing more about what you have to say about the future of health services research, of which data are a very important part.

Gerald Rosenthal, Ph.D.
Director, National Center for
Health Services Research

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Following Ruth is always somewhat of a problem. Not only does she say what you were going to say, but she says it better than you were going to say it. On the other hand, it does free me to pay attention to a few other things. This group has had a decade of promises, aspirations, experiments, and what we might refer to as "getting our act together." I would like to think it is now together and that we are really starting something that will bear some fruit, having nurtured these seeds for some time.

First, it is clear from the menu for this conference that there is a lot of health services research already underway that focuses on issues central and critical to the Hispanic communities in the U.S. The questions that lie hidden are—is it the right research, do we use it, and when two people do things that are related do we somehow put their work together? These are not questions unique to Hispanic health services research. They are questions applicable to everything that we are trying to learn systematically about the organization and delivery of health care services. But it is rare that we have an opportunity to address with such focus and precision, these issues—forgive me for using current jargon—in a holistic manner. For NCHSR, these general questions which have been our prime focus are: what do you ask about the world, how do you find out an answer, and then, how do you give it to somebody who needs it? This is what we spend our time trying to do. Ruth talked a little about the strategies that we use. Basically, the NCHSR focuses on the users of research to establish the reason for selecting an issue, the legitimization of that issue, and the ways we go about sharing what we learn with the people who need to know. We try to integrate users into our choice of research topics. Ruth did refer diplomatically and discreetly to the constraints of budget. That only means that you have to be more selective than you might otherwise like to be. That does not mean that you can afford to be less risk-taking because research is inherently a risk-taking business. It doesn't pay to invest in known answers. It only pays to pursue important questions that may lend themselves to that inquiry.

This is essentially what NCHSR is about and one of the major reasons for this conference. A lot of people here are users of research as well as doers of research. In fact, by that crude comparison, there are probably more users here than doers. That is appropriate for a conference designed to provide guidance and direction to the general independent HSR arm of the department in the federal government. We take that obligation seriously, so I would start quickly with a comment. We have had meetings in the past to learn what issues are important and what issues are not important. Ruth's hope for more meetings and more sharing is our commitment. Yes, there will be more as what we learn increases. The role of facilitating that sharing will fall at least in part on the NCHSR, and we welcome that. We accept that—we believe that is what we are in business for. The money we gave people to do things in the research side and the money for this conference is your money. It came from you in the first place; and for those of us who are up here, it is an entitlement that we are happy to be able to deliver on. So, in the research side of the world, and in the users' side of the world, we are a place to come not only for funds but for insights, for some help, for assistance, for sharing. We are eager to learn more about the nature of these issues.

We have come to understand and accept the fact that there are as many Hispanic American communities as there are diverse communities in any section of the so-called Anglo community, which is hardly Anglo if you look at their cultural perspectives and the ways they use health services. The difference between a good clinician in a primary care setting and a bad one is often the degree to which they understand these cultural differences.

It is no accident that there is a new Center for Health Care Technology. That center was born out of our growing awareness of the limitations of technology. When you acknowledge those limitations, then the reality of the people becomes the critical element. We have a lot to learn from what our colleagues here have already identified for us. We don't know exactly what those differences are, and how we can respond to them in a way to make the delivery of care more effective. To accept this reality as a place from which to start already shows that we are beginning to come at least beyond infancy, into adolescence.

Lots of things that used to be true are ceasing to be true. The relationship between education and income, for example, which was once a convenient statistical analytic reality, is no longer true. Ph.D.s' children become plumbers, social workers, and farmers, and they don't bother to finish their degrees. So, the once accurate correlation between how many letters you have at the end of your name and what your health behaviors are likely to be is now proving not to be true. That means that policies, strategies, structures, and systems that were predicated on these realities will have to change, will have to respond, and will have to shift, not only for Hispanic Americans, but for all people in this country, and perhaps for all countries. We need, at the NCHSR and at the National Center for Health Statistics, to stay ahead of that, to bring that learning to the public view, to make it operational and accessible, to make it real, and to make the system respond to the new learning and the new knowledge. That is, of course, why we are here and that is why these organizations exist. This is the unique primary obligation of the Office of Health Research, Statistics, and Technology.

The Border Health Initiative is just one more way of sharing the learning in a collaborative and collective way through an integrated research effort. We are learning things that people in New Mexico, and in parts of Texas, and parts of Southern California have known and lived with and learned intuitively for many years. For the rest of us, it is a far cry from what we live with every day, and I am grateful to those colleagues on my staff who see to it that I do not forget these issues. We want to incorporate that learning into the national effort in health services research. We welcome your direction and guidance. It is not the first thing we have done in this area, I can promise you. You know, Scout's Honor, it will not be the last, but we move towards reality, towards visions, and the harvest is always, of course, the happiest time. It is also sometimes the hardest work, but the eating of the fruit is worth the trip.

Speakers

Panoramic view of Chicano culture

Sabine Ulibarri, Ph.D.
University of New Mexico

I would like to address myself this morning to differences and similarities between the Spanish-Mexican and the Anglo-American cultures. There is a difference, and we must learn to understand this difference if we are going to understand one another in the Southwest. From the south, there comes a current of Hispanic culture. From the north and east, there comes a current of Anglo-Saxon culture. In the Southwest, there was a big lake of Indian culture. In New Mexico, these three cultures mingle, embrace, join, and reject one another.

History, geography, and providence have all combined to bind the destiny of the United States to the destiny of the Latin American republics to the south. We are bound together inextricably for better or for worse, in sickness and in health; together we will rise, or together we will fall. Together we will colonize the bright promise of the future or together we will inhabit the dark dungeons of disaster.

In the international politics of today, it behooves the United States to think seriously about Mexico. If Mexico goes to hell, it will inevitably drag the United States down with it. Remember how the entire vertebra of the North American continent shook and trembled with what happened in that little country called Cuba.

The understanding that can bring us together may very well take place, and in fact is already taking place in the southwestern part of the United States. Here we may learn to respect the differences that separate us, to learn and grow from these differences. In times of excessive individualism, we should preach of unity. In times of immoderate conformity, we should raise invectives on behalf of similarity. The cultivation of our differences is far more productive than the accumulation of our similarities. A nation's greatest resources are its human resources—talent, vision, originality, imagination, faith—these are differences, not similarities. If we could recognize and appreciate the value of the differences, we would improve our personal and international relations. It would free us from the limitations of provincialism.

We have taken over the term "America," disregarding the fact that there is a Central America and a South America. We have taken over the term "American," choosing to ignore that the Canadians are Americans also, that the Mexicans are Americans, that the Argentinians are Americans. We have taken over the term "United States," again forgetting that there is a United States of Mexico, a United States of Venezuela, and a United States of Brazil. We have taken over the term "democracy," choosing to accept only our definition of that term, as if there were no other possible interpretation. And the Spanish-speaking people are different; as we would say, *"viva la diferencia."*

One of the main differences is of a cultural nature. The United States is essentially European--European in blood, European in culture. Spanish America, including our Southwest, is only partly European, plus African, plus Indian in blood and in culture. The Moors of North Africa occupied Spain for 800 years. Eight hundred years is a big, big chunk in time, and those Africans didn't waste their time in Spain. They left many things in Spain—the dark hair, the dark skin, the black flashing eyes and the fiery blood that turns those eyes on. But they also left many other things under the skin—philosophic things, religious things, esthetic things. The conquest of the New World was carried on by a handful of men—they didn't take any women. When they arrived in Mexico, there were from five to seven million Indians living there, and these Indians belonged to many tribes and many diverse cultures. The Spaniards already were a racial cocktail. They brought with them many prejudices, but one prejudice the Spaniards did not bring to the New World was racial prejudice. The proof is to

be seen right here in our Spanish-speaking Southwest. It is to be seen in Mexico. Mexico today is *mestizo* in blood and in culture and they're damn proud of it. Mexico is very well on its way to solving its racial problems completely, at the altar, in the sight of man and God, or behind a bush, in the sight of God only.

The second major difference is to be found in the way of life of our people. The Anglo-American has an epic sense of life. The Hispano-American has a tragic sense of life. The epic sense of life functions in a homogeneous culture. The tragic sense of life functions in a heterogeneous culture. Let us look at the epic sense of life. The Anglo-American is a noble knight, out to slay dragons. You might say he's a good man. His struggle is to conquer obstacles outside the self, such as poverty, sickness, tyranny, crime, corruption, drug addiction. The Anglo-American is a heroic optimist in the war between good and evil, and I don't have to tell you which side he's on. His religion, without playing down the value of faith, stresses conduct as the avenue to salvation. He is a firm believer in the tenet, "God helps him who helps himself." Pragmatism, the philosophy of doing, the philosophy of getting things done is perhaps the best theoretical expression of the epic sense of life. Franklin Delano Roosevelt became the voice of the people and the expression of the epic sense of life when he said, "We have a rendezvous with destiny."

On the other hand, the Hispano-American has a tragic sense of life, perhaps we should say a tragic sentiment of life. His is a tragic soul, fighting to overcome itself. The Hispanic soul carries within it a conflict between the values of his Indian inheritance and his Spanish inheritance. Therefore, the battle is not between good and evil. It is a battle between two goods. His religion, without playing down the value of good deeds, stresses faith as the avenue to salvation. His religion has told him, as it has to all Christians, that this world is a valley of tears, that the good life comes later. His entire historical perspective supports this thesis. The bull fight, a ritual full of grace, symbolizes the tragic sense of life. It is the apotheosis of the individual—one man alone carries his life and his death on the point of a sword, and people on a Sunday afternoon come forward to do homage to this man alone, facing his death. If the Anglo-American has a rendezvous with destiny, the Hispano-American has a rendezvous with death. Existentialism—the philosophy of human disaster, the philosophy of human failure, is perhaps the best theoretical expression of the tragic sense of life.

The United States represents a melting pot, blending members of the same family with a corresponding harmonious result. The Southwest, Mexico, Spanish America, represent a melting pot, too, blending contrasting elements with a corresponding violence. There are two classes among our people—a select and cultivated minority that is second to none, and our vast illiterate masses—illiterate, but not uncultured. These illiterate masses have a profound intuition for cultural values. A powerful and beautiful folk art represents the culture of the illiterate. Mexicans speak, dance, sing, fight, cry, blaspheme and pray together. They are initiators and participants in the common cultural life. Our artisans are creators and doers at the same time, with a concomitant pride in the finished product, an identity with the finished product. We have deep roots in the community of our ancestors. In our society, the individual is transcendental, almost absolute, governed only by personal values.

In the United States, we are rapidly becoming a world of spectators, observers, while others perform. Specialization and technology have divorced the individual from the motherland, amputating him from the community of his ancestors, separating him from his own culture. Our educational system, the most magnificent the world has ever known, actually strangles folk art, folk creation. Our educational system is a leveling process. Simple Simon must not feel inferior to Einstein, because it damages his psyche. The nation, which proclaims the value of the individual more than any other, directs this massive educational system not to the individual, but to the masses, and the face of the one is lost in the maze of the many; the group is transcendental.

There is a psychological fact that must also be pointed out. The Hispano-American needs to talk about himself, as a human being, as a person, his beliefs, his hopes, his values, personal things. He cannot understand the resistance of the Anglo-American to open the doors of his heart. He considers talking about business, the weather, the movies, commonplace, an indication of superficiality of character. His heart controls his reason. For the Anglo-American, his reason controls his heart. Of course, I'm generalizing. I know that. If I tell you the sky is blue, that's a generalization. Anyone of you could come to me with a color photograph and prove to me that the sky is not blue. There are exceptions to everything I'm saying, on both sides.

Our philosophy in the United States is scientific. The philosophy of the Hispano-American

is poetic. Culture is emotional to a Chicano. Culture is intellectual to the Anglo-American. The Hispano-American prefers sentiment to reason, faith to intellect, all of which, of course, leads to an imperfect and disorganized life. But, oh, they enjoy it. Perfection in itself is null and void. There is nothing more perfect than a zero, and a garden arranged too well looks too much like a cemetery. The Mexicano is one of the most complex and fascinating individuals in the world.

Centuries of oppression have taught him to dissimulate. He is reserved, suspicious, but within him there is always a contained violence. On the Day of the Dead, he laughs at death, he sings. Little children buy skull candy and our wakes are fiestas. The sadness and melancholy of thousands of years are disguised in the form of laughter, joviality, noise, biting humor. He will say to you, "My home is your home," and he means it. He will give you his shirt. The only thing we never give is ourselves. On the one side, we have a native Spanish arrogance. On the other, we have a native Indian humility. On the one side, we have a Spanish spontaneity, on the other, our inherited Indian tenacity. We all have an inferiority complex. We all sort of feel we have inherited an inferior culture. Our Indian hat belongs to a conquered race. We are the illegitimate children of a Spanish father and an Indian mother, and our father has ignored us. And we have never forgiven our father. Our poverty is centuries old, and destiny has placed us next to Texas. Every time we speak to a Texan, we have to look up, and that does something to you. We are situated on the fringe of the United States, representing the much and the big, so in self defense, we strive for the small and the elegant.

The Mexican is not lazy in spite of the caricatures of the Mexican peon with his hat pulled down over his eyes, leaning against a cactus. They make nice bookends, don't they? Many of you probably have traveled through Mexico. I am certain you have never seen a Mexican leaning against a cactus. Oh sure, the Mexican takes a *siesta* because he's smarter than we are. You may have seen a Mexican *peon* asleep at two o'clock in the afternoon, but not in the noonday sun, not against a cactus—in the shade! And what the tourists may not know is that the Mexican sleeping in the shade got up at three o'clock in the morning to work in the fields, when it was cool, when it was intelligent to work in the fields, and he sleeps at two o'clock in the afternoon when it would be stupid to work in the fields.

They call this country the land of *mañana*—sometimes for romantic reasons. American schoolteachers go to Mexico for summer school and they expect to find romance behind every bush, and they probably do. Sometimes they call this land the land of *mañana* for malicious reasons. I feel that this land is indeed the land of *mañana*. History has shown us that there are nations with a glorious past. France and England belong to that category, don't they?

There are nations with a glorious present—the United States, Western Germany, Japan—they have a glorious present. And there are countries with a glorious future—a glorious *mañana*—Mexico belongs to that category.

Mexico has achieved political and economical stability that is far superior to any of the other Spanish-speaking republics. It has solved most of its racial problems. There are factories belching smoke and steel, new cars on highways, planes in the air. In some areas, Mexico is the teacher of the world—architecture and painting, for example.

If there is to be understanding among you on this side of the border or on the other, we have to realize that there is more to Mexican culture than tacos, tamales, and tequila. And they, on the other side, have to realize that there is more than Coca-Cola, french fries, and hotdogs to the culture on this side. Both peoples have much to learn from each other. To be sure, we have different attitudes, but these different attitudes complement each other. Both peoples share the same thing, the same noble and heroic concept of man, the same humanistic vision of life, and *"viva la diferencia."*

Accountability in Hispanic health services research

Faustina Solis, M.S.W.
University of California, San Diego
Medical School

Can you recognize the significance of this momentous occasion? It is the realization of a conference which one attributes not to a few individuals but to the diligent efforts of many people over a period of no less than 20 years. It is with some regret, but not discouragement, that we acknowledge the absence of the very basic tools which we need so desperately to develop viable resources of care for our population. In 1967, cabinet hearings on Mexican-American affairs took place in El Paso, Texas, with HEW Secretary John Gardner as moderator. One of the major issues at that conference was the lack of basic data on Spanish-speaking populations. That was in 1967. I might add that when that conference was organized, it was simply by chance that the health component was included.

We have come 12 years, and today we still regret there are not the basic data on which to continue the development of resources. We are on the threshold of a new venture, and for this reason I was prompted to speak on accountability; perhaps the definition of that word may be rather unorthodox. As a matter of fact, I had thought earlier that I would title the presentation "The Spectre of Accountability" because "accountability" is a word that evokes a rather negative connotation to most of us. We equate it with compliance, regulations and the measurement of compliance for contractual agreement. I am not speaking about that type of "accountability" at all. When I speak of accountability, I am referring to the measurement of responsible commitment. As professionals and members of the Hispanic population, we cannot discard this commitment. There have been a number of studies in previous years ranging anywhere from descriptive studies to the attempt to develop some basic data, to some research endeavors, usually single studies of health care utilization and accessibility, migrant health, sociocultural components on maternal and child health, morbidity, selected morbidity reports of the importance of language and other topics.

I had the opportunity to review 51 of the abstracts submitted to Dr. Salazar for this conference. Within the group, the predominant interests seemed to be in sociocultural access to health care, reproductive health, utilization and curriculum for health manpower training. These are all very necessary and important issues of the day. How we set the priorities for consideration is a matter of debate and talks which will certainly take place in some of your deliberations. According to the figures given us today, there are 16 to 20 million Hispanics, and more than 42 percent of this group are under the age of 18. This figure represents our children. How much do we really know about Hispanic children? We say the hope of the future is our children. The Hispanic hope does not seem to be very crystallized. What do we know about the levels of mental retardation? What do we know about the handicapping conditions of childhood or the handicapped in the Hispanic community? Dr. Rice referred to the lack of morbidity data, particularly regarding children. Dr. Breslow referred to undocumented persons and their rights to health care and survival. The whole of the issue of indigent care, which increasingly becomes a problem or is made a problem in local jurisdictions, is another current and increasingly greater issue.

I would like to speak a little bit about health manpower training. This year we prevailed upon the University of California's School of Medicine to introduce a non-elective course in the Spanish language for residents in family medicine. Each new student who will be considered for residency in family medicine will be required to participate in the Spanish class. It is not sufficient to talk about language unless it is integrated with the broader cultural components of doctor/patient relationships. Now let me speak to the cultural components because you may think everybody understands what is meant by sociocultural components. I reviewed the literature selected for the residents' reading. It may be,

ladies and gentlemen, that we have romanticized *Curanderismo* and folk medicine, to the exclusion of really considering the value of the cultural components. Cultural components are not synonymous with folk medicine. I believe these are some of the crucial issues that need to be addressed so we can interpret and understand among ourselves how we define cultural components, and how we utilize this knowledge in every instrument that we develop. Some of the survey instruments that have been organized and developed cause me the same concern when they are translated. We are translated to death, and yet we are not communicating. Some materials should be developed in the language in which it will be used, not translated from another. Likewise, we must develop the expertise in relation to research instruments that may incorporate the cultural component that is interpretable.

In speaking about the health of the Hispanic population, I cannot be limited to health care facilities, health services, and delivery of services because the world is very complex. The variables affecting our health are multiple. What do we know about the occupational diseases of Hispanics? Now, that belongs to another department. It belongs to another bureau. When I was doing some work on the Public Health Division of the State Health Department, I remember an industrial hygienist coming to me and saying, "My, I don't want to inspect that factory again. It was one of the most depressing experiences that I have ever had, and I have been doing this for a long time." In addition, he said, the safety and health hazards were so numerous that many of the workers were inebriated. "I am sure," he said, "that you would have to be inebriated to work there." But maybe somewhere, someone was doing something about the alcoholism. But what are the conditions creating some of the problems we so desperately are trying to eradicate or control?

It reminds me, too, 13 or 14 years ago, when I went to one of our universities where they were developing machinery to replace farm workers. And one of the monstrosities of machinery being developed was one which would strain the hops; not only would it strain them, but it would make a bulb at the end. Then we had a tomato harvest and time was spent in developing a tomato which would not be bruised by the harvestor. Little time was spent in following up the health of the people who would work on the tomato harvest and use the harvester.

In those days when I was going to labor camps, I spent some time at the laundry unit where women would get together and I would learn from them some of their concerns and how some of the programs were developing. One day they said, "You know, there have been five miscarriages among the women in this camp . . . and we wonder if it has anything to do with their working on that tomato harvest." I proceeded to go to the Public Health Department and ask about any side effects or hazards to health from the work on the tomato harvest. And they said we haven't heard anything about it. What kinds of data do physicians have on the occupations of these women? And you know, you've looked at those clinical records—they say "farmworker." They never say what they do. The occupation itself is not going to tell you what the hazards are. There is no follow-up. When I talk about our responsibility and accountability, it cannot be narrow and it cannot be restricted to a specific group. What is so exciting to me, seeing you here, is that with your expertise you can take a global view of this whole area of the Hispanic population.

Now the other area which will be discussed in greater detail and is of special interest to me is that of binational activities. It is unfortunate we have to have political boundaries, because disease has no boundaries. For more than 40 years there have been alliances between Mexico and the United States, looking at special health issues on the border. But we have been rather timid on our side of the border. We have been very timid about identifying what we can do on behalf of border populations. I really hope and trust that the Border Initiative will do more than to fund what we know is already there.

My last point deals with priorities. Whenever we interject or intervene on behalf of different sectors of our population, we do so because funds have become available. With all due respect to my colleagues from the federal bureaucracy, and I know them and have regard for them, there is just so much they can do. We should be determining those priorities at the level that they are created. They should not have to wait endlessly for their own staff to develop certain kinds of priorities. How much are we aware of the trends in our community? How much are we aware of the changes, and what do we do with them?

Single parents with children—this situation has been incremental for the past three years or more and is easily documented. We do not provide equal services to them, indeed we exclude them because we do not recognize their state. We do not recognize the fact that a single parent has one major priority: the survival and the support of one or more children. We tend to imitate the going institutions as much as we might give lip service to the necessity to tailor our services to the needs that we have. We cannot continue this practice. We cannot afford to victimize our population. We must be able to move forward and be able to identify the areas before they become criti-

cal. There is so much untapped and unrecognized creativity. Don't be timid. This needs courage. You are not embarking on a project which is easy. It is going to demand a great deal of discipline. It is going to demand a great deal of patience. You are going to learn how to work with people you have never known before. All of us as professionals make certain commitments based on the quality of our performance and the dignity of our functions. That must be proved over and over again. Not for us, but for the population that brought us here today.

Developing an Hispanic health services research agenda

Carlos Vallbona, M.D.
Baylor College of Medicine

No one will question the profound cultural differences that exist between the Hispanic population, the Anglo population and the black population in the United States. To illustrate this point, I would like to relate to you the story of a very famous cardiologist in Houston who used to see a lot of people from various parts of the world. Once he was visited by an illustrious-looking, middle-aged man who said, "I come to you because you are a very famous cardiologist in Houston, and I wanted you to give me a check-up." So the cardiologist said, "Fine, let's ask a few questions first," and asked, "How old are you?" The man said, "45 years of age." The cardiologist said, "That's fine; that happens to be my age too, so we are really in the age group that we are very productive and supportive and so on." For every answer, this man made a commentary. He then asked the question, "How often do you eat?" And the man answered, "Three meals a day." And the physician said, "Is one of them breakfast?" And the man answered, "Yes." "Well," he said, "breakfast is a very important meal, so I am delighted, but what about drinking?" He said, "Well, I drink wine with my meals." "Great, because wine increases the proportion of high density lipoprotein and high density cholesterol, it is good to counteract the effect of foods that might increase your cholesterol level." (I told you, a comment for everything.) "What about exercises?" "Yes," he said, "I play tennis as much as my job permits, and I swim a little bit." "Great, because exercise has the virtue of eventually lowering your heart rate." Everything was going along great, and then he said, "What about your sexual life?" And the man said, "Well, occasionally, maybe once every six months." And the cardiologist said, "Wait a moment—once every six months—look at me: 45 years of age, and at least once a week." And the man looked at him and says, "Sir, one thing is to be a cardiologist in Houston, and the other is to be the Bishop of Baja, California."

Obviously, the cardiologist in Houston failed to realize that there are cultural differences that have an impact on health attitudes and health beliefs. I don't think that we are quite clear yet on what is the extent to which these differences do affect the health status and the health service utilization of Hispanics in the U.S. The reason, of course, is that we do not have the data bases needed for making warranted conclusions. Why don't we have these data bases? I would suggest to you that there are two major reasons. One is that not until recently has there been a perceived need to investigate the peculiar differences of the Hispanic population because, first, it was felt that there were too few Hispanics to warrant a special study. Also, it was felt that their cultural assimilation with the majority Anglo population occurred very rapidly, and that there was little in the Hispanic culture that could influence health beliefs and health services utilization. That, of course, is not true. However, in my opinion there is another major reason. It is the great difficulty of carrying out meaningful health services research activities as they relate to the Hispanics because of the lack of homogeneity of the population base, which is the object of the study. This lack of homogeneity, of course, stems from difficulties in identifying first who must be included in the Hispanic population. If this is not sufficiently difficult, there is even greater difficulty in classifying the Hispanic person within the appropriate ethnic group. If you think that the health beliefs, the health attitudes and health services utilizations of the Puerto Ricans of New York are similar to those of the Mexican-Americans of Houston, Texas, I can tell you right now that you are mistaken. Indeed, when we speak of Hispanics, we speak truly of a mosaic of ethnic groups, and each one of them has its own peculiarities. We do not know yet precisely how these pecularities affect their health status or their health services utilization.

It is my personal bias that the health status of the Hispanic population is to some extent a function of the socioeconomic level of individuals. On

the other hand, differences in the health needs of Hispanics are not solely attributable to differences in income. I believe, as Ms. Solis does, that even if we were to adjust for income, cultural differences would affect the outcome of the health care delivery system. Profound cultural differences will have a major impact on the structure of the health care system. Perhaps the most important aspect of this influence is that it is brought about by differences in the health attitudes of the Hispanic population.

Much has been written about the differences in the health attitudes of the Hispanic population, and a lot of platitudes have been passed from place to place, from mouth to mouth. Some of these platitudes are now being dispelled. One says that the following are health beliefs and attitudes that must be taken into consideration if we analyze the health care needs of the Hispanic population: (1) A fatalistic attitude toward illness—who cares? Wrong—they care. (2) An inadequate knowledge of the early signs and symptoms of the illness. Wrong—some of them are very sensitive to the earliest stages of a derangement in the bodily functions. They may not articulate in the same terms that we are articulating now, but maybe we can learn a great deal from them if we listen. (3) Inadequate awareness of risk factors. Wrong—Many of them are as aware of the risk factors as we are. They may not be aware of the risk factors in terms of cholesterol and density like lipo-proteins, etc., but they are aware of some of the risk factors, if not all of them. (4) Lack of interest in crisis care and prevention. Wrong—they are interested in prevention as much as we are. (5) Poor compliance to prescribed treatments. True—but whose fault is it? Have we communicated sufficiently about the importance of adhering to therapeutic regimens? (6) Adherence to folk medicine—what does that mean? Does it mean paying attention to the advice of grandmother? Well, is that different from the advice of the Jewish grandmother about chicken broth? You all know that there seems to be some scientific proof about the value of chicken broth in the treatment of some acute infections. Well, they say that uneducated Hispanics believe that illnesses are due in part to chance, but mostly, they attribute them to a divine desire to test the individual's capacity to endure suffering or to punish him or her for some past act that was against the divine or human law. Well, studies conducted by Mrs. Amelie Ramirez of the Communications Corps of Baylor's Heart Center have shown that Mexican-Americans certainly are not well aware of early signs of illness, especially those of cardiac emergencies, and that they are not well aware of some factors associated with heart disease. But, as was pointed out this morning, their level of awareness is higher than that of the black population.

Belief in folk medicine is quite prominent among the low income Mexican-Americans, and there is no abundant literature on the health beliefs and attitudes of Hispanics. The classic work of Jerry Weaver in 1973 pointed out that studies conducted up until that time proposed a series of hypotheses which Weaver classified according to three generations. The first generation started with the pioneer work of Saunders in 1964. Saunders stated that folk medical beliefs or practices were the rule; that health was seen as a matter of chance; and that younger Mexican-Americans would have a more scientific medical orientation than their elders. The second generation of hypotheses was put forth by Rubel in 1960 and 1964, and by Madsen in 1964. They stated that participation in folk medicine varies inversely with social class; that resistance to Anglicization prevented acceptance of scientific medicine; and that folk healers were more identified with persons who wished to maintain their Mexican-American identification. Last, we come to the third generation of hypotheses postulated by Moustafa and Weiss in 1968, by Nallings in 1967 and by Weaver himself in 1973. This third generation of hypotheses indicated that there was a negative attitude to Anglo institutions, including health care systems, and that Mexican-Americans who belonged to close-knit family units were inhibited to accept scientific practices. I do not think that this is true, and Dr. Emil Farge—who is here from Baylor, too—published the results of his extensive research work on urban Mexican-Americans of Houston. He compared only two aspects of the various hypotheses previously advanced. He indeed confirmed that participation in folk medicine varies inversely with social class, but also he found that folk beliefs do not conflict with scientific health care practices. In our personal experience with the network of community health centers in Houston, three of which serve a predominantly Mexican-American population, we have found that a similarity of beliefs in folk and scientific ideas exists and that there is an acceptance of perfectly compatible scientific and folk health practices. Now, if this is the case, then we have to ask what kind of issues are pertinent to us in the health services area? If you allow me just three or four minutes, I would like to read to you several research questions that I and members of my department have posed among ourselves in an attempt to establish with a greater degree of clarity what the health care needs of Hispanics are, and how the health care system can be more responsive to these needs:

1. What is the level of utilization of health services by Hispanic persons by specific ethnic origin and socioeconomic status? The statistics presented in the advance data population which Dorothy Rice showed us this morning failed to show the differences between these various ethnic groups and their socioeconomic status. We feel that it is extremely important for us to know this in greater detail.

2. What factors lead to the utilization of health services by young and middle-aged low-income Hispanic males? A lot of hypotheses have been advanced that the macho Hispanic male cannot accept the notion that he is ill, although he is as vulnerable to illness as anybody else. Nevertheless, he does not go to the physician in the same proportion that the Anglo male would go, or according to some hypotheses, that the black male would go. The question is why?

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3. What attitudes may be fostered through health education programs that will lead to greater utilization of preventive care?

4. What is the attitude among Hispanics toward the elderly population, and what is the level of utilization of nursing home care by the Hispanic elders? Here we have a major area of concern. Ms. Solis emphasized this morning the importance of looking at the young population. I submit to you that it is equally important to take a hard look at our elderly Hispanics and see how they cope with their illnesses. I know we can learn a great deal from them.

5. What is the influence of religious beliefs on the acceptance of family planning methods by young Hispanic women?

6. How effective is the communication between provider and consumer in the face of language and sociocultural barriers? We talk a great deal about patients not complying, but have we made clear to the patient the importance of complying with the treatment?

7. What is the level of compliance to prescribed treatment regimens and what are the obstacles to achieving good compliance?

8. What educational programs are most cost-effective in modifying the dietary habits of low-income Hispanics?

9. What is the extent of folk medicine utilization among Hispanics of various ethnic and socioeconomic groups?

10. Can networks of folk healers be described adequately in terms of the structure and the process of that system and can they be integrated with a scientific health care system?

11. What motivating factors can be fostered among Hispanics to enter health careers?

12. What factors have led to better integration of Hispanic physicians in professional organizations? That has not been the case for black physicians. If you look at the county medicial societies, you will see that the Hispanic physician has been perfectly integrated; yet the black physician has not been perfectly integrated. The question is why?

13. Is there a desire to maintain the Hispanic identity among the ever-increasing number of young Hispanic health care professionals? If they do not wish to maintain such an identity, why not?

14. Will there be any difference in the acceptance of cost containment policies between Hispanic providers and consumers?

15. Can Hispanic paraprofessionals be trained to promote preventive health practices in low-income Hispanic barrios or neighborhoods?

16. What type of health care promotion activities targeted to Hispanics would be effective at the work site?

I would like to believe that if we answer only a few of these questions, we would do much to promote health care delivery and health services research.

Before I finish, I would like to emphasize the importance of the quality of the health services research that we should conduct. We must, indeed, adhere to strict principles of experimental design, data analysis and interpretation. Unless we produce meaningful results, the impact of our activities will be that of poorly justified and often biased statements, and they will not have any influence whatsoever on health care policies for the future.

Now, what about our task forces? What are we supposed to do today and tomorrow? Your organizing committee felt that there were four major issues that each task force should deal with. Task Force 1, as you know, addresses the impact of national, regional, state and local health policies on health services for Hispanics. You heard this morning a beautiful example provided by Dr. Breslow regarding proposed health policy for the people of California, which would have affected thousands or hundreds of thousands of Hispanic people. Task Force 2 is supposed to address the sociocultural influences on health services research and on the health services systems for Hispanics. Task Force 3 addresses the issue of resource development strategies for conducting Hispanic health services. And lastly, the task force that I am going to be working with will address the issue of how can we facilitate timely dissemination and assessment of the results of Hispanic health services research. Along these lines, we want to work very closely with our neighbors from south of the Border, from Central and South America, and from Spain, because a lot of inferences can be made about the delivery of health

care, utilization in a variety of health care delivery systems, and a multitude of health attitudes in all the countries that we have a tendency to label together. We are going to address these issues.

I would like all of us now to walk to our conference rooms and get to work on our tasks. Then, let's run to our grant applications—to whatever institution will accept the importance of health care research for Hispanics—and through the results, let's fly to accomplish our major goal, which is an improvement of the health status of the Hispanic population of this country. We are talking of potentially 50 million people—50 million people who are part of the United States of America, part of this continent, and part of a world that is shrinking very quickly.

Task Force 1: The impact of national, regional, state and local health policies on health services for Hispanics

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Task force participants:

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Hispanics and Health Systems Agencies

Anne G. Gurnack
Access to health care in an Hispanic community

Virginia C. Kennedy, Ph.D.
Factors affecting the choice of a medical care source: Hispanic-Anglo comparisons in a rural population

David Maldonado, Jr., D.S.W.
Sociocultural dynamics in the delivery of human services to Mexican-American elderly: a look at the *ancianos* and their family networks

Jude Thomas May, Ph.D.
The analysis of emerging health policy: a model drawn from the Neighborhood Health Center program

Yolanda Archuleta Muñoz
Indigenous control of health services in a small Hispanic community

Juan de Dios Pozo-Olano, Ph.D.
Medicaid and the Hispanic American population

George A. Silver, M.D.
Impact of national and international health policies on child health services with special reference to Hispanics

Doris P. Slesinger, Ph.D.
Health care utilization patterns of Hispanic migrant workers in a receiving state

Manuel Spector, Ph.D.
Cultural diversity in health-poverty as a barrier to Hispanics and undocumented aliens

Fernando M. Treviño, Ph.D.
Community mental health center staffing patterns and their impact on Hispanic use of services

Mauel Zapata
Impact of the kidney health care program on Hispanics in Texas

Michele Zebich, Ph.D.
Health care of the undocumented worker: policy issues and legal dilemmas

An Hispanic Health Services Research Conference sponsored by the National Center for Health Services Research and in collaboration with the UCLA School of Public Health and the University of New Mexico Institute for Applied Research Services took place on September 5, 6, and 7, 1979 in Albuquerque, New Mexico. The purpose of this conference was to discuss important issues related to the development, implementation, and evaluation of Hispanic health services research. The conference was divided into four workshops or task forces, which addressed the following areas of concern: (1) The impact of national, regional, state, and local health policies on health services for Hispanics; (2) Sociocultural influences and health services delivery for Hispanics; (3) Resources development strategies for conducting Hispanic health services research; and (4) Facilitation of the timely dissemination and assessment of Hispanic health services research.

Prior to the conference, papers addressing these issues were solicited from academic institutions, governmental agencies, private foundations, and organizations providing health services throughout the United States. These papers were presented and discussed in each task force. This paper provides a summary report of the major deliberations of Task Force 1.

Task Force 1 was charged with documenting previous health services research showing the impact of national, regional, state, and local health policies on delivery of health services to Hispanics and specifying additional research needed to inform future health policy regarding Hispanics. Many of the papers submitted to the conference addressed topics in more than one of the task

forces. Consequently, the deliberations and recommendations of the various task forces tended to overlap somewhat. However, the Task Force 1 moderators encouraged presenters (authors of papers) and observers to focus on the policy relevance of the issues they discussed.

For the purposes of this task force, "health policy" was defined as the goals and objectives of health services delivery as well as the means or practical procedures to accomplish these goals and objectives.

The Hispanic Health Services Research Conference brought together Hispanic and non-Hispanic researchers, users of research data, providers, consumers, and students. All of these interests were represented in Task Force 1 and, consequently, a variety of opinions were expressed with a great deal of interaction focusing on the usefulness or application of health services research to planners, administrators, and providers.

Fifty to 60 people attended the various sessions of Task Force 1. Approximately 50 percent of the participants of the task force were presenters and 50 percent observers. Hispanic representation was close to 40 percent. A great number of them were Mexican or Mexican-American; others were Puerto Ricans, Cubans, and Hispanics of Central and South American origin. Some of the Hispanic participants were first generation in the U.S.; other Hispanics came from families who have been in the U.S. for several generations. Some Hispanics were primarily English-speaking, and others were completely bilingual. A good number of non-Hispanic participants were bilingual and bicultural.

The activities in Task Force 1 were structured in the following way: 15 minutes were given to each presenter to summarize his research paper by focusing specifically on the research problem, methodology, findings, and recommendations. Ten minutes were then immediately provided for floor discussions. These included criticisms, comments, and questions on the relevancy of the research paper for health policy. Twelve papers were presented and discussed during the two days that the task force met.

The issue of Hispanic access to medical care frequently came out during the deliberation of this workshop. Some general concerns were: why do Hispanics have lower access to medical services in comparison to other ethnic groups; what are the determinants of access to medical care in rural areas; and how can health manpower distribution in rural areas also increase accessibility of medical services among Hispanic populations. Of particular concern was access to medical care for migrant workers.

Barriers to access discussed in this task force include language barriers, cultural values, geographic isolation, economic restraints, lack of Hispanic paraprofessionals and community involvement in the planning and development of health services.

Some methodological issues related to research design were raised. Some participants were concerned about sampling techniques, development of the instruments (e.g., questionnaires), and difficulties in the general collection of the data on Hispanic health.

Many participants addressed their concerns toward particular Hispanic subgroups. It was stated that the needs of Hispanic elderly were frequently ignored and that the Hispanic elderly have become increasingly isolated. Therefore, there was a great need to evaluate ongoing programs which serve the Hispanic elderly.

Similar concerns were expressed about Hispanic children and adolescents. It was stated that there is a high childhood mortality rate among Hispanic children and that more preventive as well as treatment programs should be developed. In addition, there is a need for advocacy policies for children.

More perinatal health research (e.g., epidemiological studies) as well as expansion of preventive health programs were emphasized as a means of reducing the number of high-risk factors during pregnancy and infancy.

Lack of awareness of Hispanic health needs, as well as lack of coordination, were noted at all levels of the health delivery system from state and federal agencies to local community health services providers. Considerable discussion focused on the special needs of undocumented workers, both in terms of their eligibility for existing programs and the need for new programs to address their unique health problems.

The specific recommendations of Task Force 1 concerning future health policy research are divided into three categories: (1) policy formulation, (2) program implementation, and (3) program evaluation. Policy formulation research produces information that can be used in deciding what the goals and objectives should be and documents how these decisions are made. Implementation research develops operational plans or programs for reaching established goals and objectives and studies the process through which these health services programs are established and maintained. Program evaluation assesses the efficiency and effectiveness of the program in reaching its goals. Did it accomplish what it was supposed to? The following recommendations came both from the papers presented and the discussions following them.

Policy formulation research topics

1. In order to formulate policy, we need much more basic descriptive information on the characteristics of Hispanics, including demographic, social and economic data. We need information concerning health beliefs, immigration history, means of financing health services, availability of health facilities and personnel, morbidity and mortality patterns, health and illness behavior, and the utilization of health services.

2. For informed policy formulation, we need the above information for subgroups as well, including those defined by region and ethnic origin, infants and children, adolescents, pregnant women, the elderly, migrant workers, and undocumented workers.

3. We need to improve our understanding of the current relationship between the elderly and their extended families and the type and amount of support families provide.

4. Policy formulation needs to take into account the broader society (for example, how children and the elderly are treated). Also, issues of rapid secular change and modernization must be considered when formulating policy for various Hispanic groups since their needs change as well.

5. We need a better understanding of how national policy is formulated. Possibilities include emulation of state models, initiative on the parts of legislative, judicial, and executive branches of the government, and direct pressure on the part of the population.

6. We need further investigation regarding the extent of mental illness in the Hispanic population and examination of the assumption that Hispanics are underutilizers of mental health services.

7. More work is needed on ways to involve Hispanics and to secure their active participation in health planning groups that formulate policy.

8. In formulating policy for undocumented workers, efforts are needed to show the extent to which they are "burdens" or "assets" to the health care system and the economy in general. We cannot rely on institutional records since many undocumented workers may not present themselves for service.

9. Policy formulation would benefit considerably from uniform record-keeping procedures by those organizations providing care to Hispanics and the integration of mental health and physical health data.

Program implementation research topics

1. Given the need to deliver services, we cannot always wait for sufficient "baseline" information. Sometimes programs must be developed and tried with limited knowledge. Subsequent evaluation research could then lead to modifications.

2. We must explore strategies for bringing Hispanic consumers into the planning of service delivery to increase chances that a program will survive and prosper.

3. Before influencing policy, we must study how policy is formulated. For example, we should better understand the relationship between lay and professional control in determining health agency operating procedures.

4. The assumption that greater consumer participation in program planning leads to better fit between services provided and population needs should be tested and refined in terms of type of participation, characteristics of providers and consumers, etc.

5. Studies are required about how health programs can encourage Hispanics and particularly undocumented workers to seek services.

6. We need much more work on how to bring about effective local control in health agencies, under what circumstances consumer boards actually represent consumers, and how funders' regulations impact on local health organizations.

Program evaluation research topics

1. Underutilization of neighborhood health centers, when community needs appear to be great, should be further assessed.

2. What is the impact of community, city, county, state, or federal control of health services delivery on utilization by Hispanics?

3. Under what conditions will the placement of new health facilities and personnel in shortage areas result in their utilization by Hispanics as opposed to continued use of old sources or not seeking care at all?

4. What is the impact of health practitioners other than physicians on patient control and utilization of health services?

5. Do efforts to increase patient knowledge of the availability of health services increase patient use of services?

6. Does administration of health facilities by Hispanic administrators have the impact of increasing Hispanic use of services? If so, what are the reasons for this happening?

7. What role would improvement of financial coverage for health services for Hispanics play in increasing their utilization of services?

8. Do special programs such as kidney dialysis function as well for Hispanics as for the rest of the population? If not, why not? For example, are there particular barriers that limit Hispanic use of home dialysis?

Anne Gurnack
Access to health care in an Hispanic Community

The author stated that while there seems to be a need for more community health facilities in Hispanic "barrios," we also need to discover why Mexican-Americans have lower utilization rates.

Addressing this issue, some observers asked questions about the socio-demographic characteristics of the subjects in the sample, reasoning that differences in use may be related to differences in population characteristics. The author responded that there was no information available on the respondent's generation, place of birth, length of time in U.S., etc., nor did the study differentiate between migrants and non-migrants. Some participants felt more attention should be paid to measure of health status since a critical issue in access to medical care is how much care people obtain relative to their need as measured by health status. Therefore, based on some of these concerns, it was recommended that to study Hispanics' access to care, we must consider age, generation, knowledge on resources, documentation, health status (mortality, morbidity), and health beliefs.

Discussion continued on the general issue of whether or not neighborhood health centers are under- or over-utilized. Some observers stated that they, as administrators of health centers, have been successful in reaching the Hispanic community. Another observer stated that as an administrator, his biggest problem was the high percentage of patients who did not show up for appointments. He has been dealing with this problem by calling the patients the day before to remind them of their appointments.

It was generally agreed that local or community control of health programs (versus city, county or state) increased levels of access.

Virginia Kennedy, Ph.D.
Factors affecting the choice of a medical care source: Hispanic-Anglo comparisons in a rural population.

Addressing the issue of the distribution of manpower in rural areas, some observers felt that we need to know more about the possible impact of more medical manpower in these areas. We need to know more about how it will affect those already linked to the medical system and those who are not. The group felt that the proximity of medical facilities does not necessarily induce people to use those facilities; other factors such as cost, type and quality of services, etc., may be more important.

The involvement of community residents in the planning process was also viewed as important. Community residents should be asked what is acceptable to them. It was proposed that if users as well as the health providers were involved in the planning process, use of facilities would be maximized.

David Maldonado, Jr., D.S.W.
Sociocultural dynamics in the delivery of human services to Mexican-American elderly: a look at the ancianos and their family networks

Discussion emphasized the need for more data on the Hispanic elderly—data on age distribution, longevity, morbidity, inter-generational differences, etc. These data will serve as basic guidelines for establishing priorities and developing policies. Because the problems of the Hispanic elderly mirror the problems of the elderly in general in our society, a possible framework is to study social factors first (those common to Hispanics and non-Hispanics), then the cultural factors (differences in values, informal support systems, etc., between Hispanics and others). The rationale is that we generally treat the elderly as we treat children and other groups in society that we identify as "helpless."

Other issues discussed briefly were: the role of Medicare and Medicaid in treatment of the elderly; the need to evaluate on-going programs providing services to the elderly; and the need to develop retirement benefits, either through social security or other means, for the Hispanic elderly who typically have few resources to rely on.

Jude Thomas May, Ph.D.
The analysis of emerging health policy: a model drawn from the Neighborhood Health Center Program

This paper focused on the study of initial stages of program experimentation and development as a way to understand health policy. It was based on in-depth, focused interviews with approximately 80 key individuals associated with the Neighborhood Health Center Program sponsored by the Office of Economic Opportunity and the Department of HEW. It argued that early policies developed on a trial and error basis were later formalized with only slight modification.

Most of the discussion regarding this paper referred to the methodology used by the researchers: case studies through intensive interview of elite leaders responsible for policy formulation and policy implementation.

One issue raised was how to corroborate the information provided by the interviewee—how do we know that the respondent is telling the truth? It was suggested that we need to look at records or other documentation for verification. Another issue raised was that the authors did not sufficiently consider the roles of legislators and community people in the development of health policies.

Some expressed concerns about the standardization of the responses. How can the data be analyzed with minimum biases involved? The authors did not face this problem because they interviewed the respondents themselves and their approaches were considered similar. They themselves did not know if it is feasible to train interviewers to collect this type of data.

The relevancy of this study to serve the Hispanic population was discussed. The author stated that this research was geared to provide information concerning the whole process of how policies are developed, using a neighborhood health clinic as an example. The role of professionals other than medical staff was studied, as well as the role of the paraprofessionals in the initiation and innovation of health services.

Yolanda Archuleta Muñoz

Indigenous control of health services in a small Hispanic community

On the basis of historical descriptive research, the presenter explained the roles of consumer participation and advocacy in a health clinic located in a rural Hispanic community. The study took place over a 20-year period during which the development, operation and management of a local health clinic were under the control of a local church. After some conflict, a local consumer board of directors gained control.

The audience was interested in more details about this case study. What alternative sources of funding were available to the consumer board of directors following separation from the church? An issue regarding the accountability of the board was also raised: Did the community actually want the board to separate from the church? Other questioning concerned the Hispanic representation on the board and in the church.

Juan de Dios Pozo-Olano, Ph.D.

Medicaid and the Hispanic-American population

Conference participants agreed with the author's position that the Medicaid program is not prevention-oriented. Medicaid finances services only when an individual is ill. The red tape involved in the eligibility and treatment procedure is enormous for health providers as well as recipients.

The lack of information available to the general population, especially Hispanics, regarding the program's regulations, rights and benefits was discussed intensively. It was suggested that policy research should study the characteristics of the population receiving aid and also those eligible for such aid but not taking advantage of it. This information should be provided to federal and state agencies. There is a tendency to rely on the federal government for solutions, but these solutions are often inappropriate without local input because they are insensitive to "grass root" problems.

George A. Silver, M.D.

Impact of national and international health policies on child health services with special references to Hispanics.

Conference participants seemed to agree about the need for more protective and medical services in areas of prevention and treatment for all children. Hispanic children have unique needs due to social and cultural factors.

The author felt that Congress seems to be more interested in children's problems, especially in the last three years, but they deal with children's needs in a fragmented way, not from a holistic point of view. Because in the author's view, politicians are not concerned about policy research, policy research development and implementation should be conducted by community groups.

The author also felt that in those states heavily populated by Hispanics, Hispanics should develop health programs which could then serve as models for other states and subsequent national policies. The rationale for this is that historically national programs have followed state examples.

Finally, the author stated that there is a need for more epidemiological studies and analyses of neo-natal and post-natal deaths to help determine the gap of services and to aid in setting priorities for programs.

Doris P. Slesinger, Ph.D.
Health care utilization patterns of Hispanic migrant workers in a receiving state.

A survey of a 10 percent stratified random sample of Wisconsin migrant agricultural workers, 90 percent of whom claimed Hispanic heritage, was conducted from July through September 1978. The survey results indicated low utilization of health services, although the author noted that there seemed to be a greater utilization of services by bilingual workers and those who work in canneries rather than fields.

This study showed the importance of timing in doing studies of migrants. Many migrants were not interviewed because they had left the labor camps before the interviewers could reach them.

Fernando M. Treviño, Ph.D.
Community mental health center staffing patterns and their impact on Hispanic use of services

The findings of this study indicated that: (1) There is no significant under-utilization by Mexican-Americans of any of the eight community mental health centers studies; (2) Community mental health centers with a higher proportion of Mexican-American staff had higher utilization of services by Mexican-American clients; (3) The median age of the Mexican-American client was 27. This median age was lower than for Anglos and blacks, but it is not representative of the age structure of the Mexican-American populations in the communities served by the centers; and (4) Mexican-American males had higher utilization of services, especially for drug-related problems and alcoholism. Notably, the centers with Mexican-American administrators tended to have higher utilization by Mexican-Americans, suggesting that treatment staff may not be as crucial as administrative staff, who have responsibility for program formulation and implementation.

Workshop participants felt that the study should have taken into account sociodemographic characteristics, as well as the incidence of mental health problems in the study population and other variables such as unemployment rate.

Manuel Zapata
Impact of the kidney health care program on Hispanics in Texas

Some of the discussion of this paper focuses on whether kidney failure can be prevented, and the advantages of dialysis at home. According to the author, dialysis prevention is not possible, but the chronic diseases attached to it can be. The author considered home dialysis advantageous to the patient and less expensive. However, whether it will take place in the hospital or at home is usually decided by the physician. The patient who receives dialysis at home needs back-up services, but whether the federal government can cover the cost of these back-up services still needs to be explored.

Michele L. Zebich
Health care of the undocumented worker: policy issues and legal dilemmas

This paper generated considerable discussion concerning the extent to which the health problems of undocumented workers impose financial burdens on the communities in which they work. The audience's position in general was that undocumented workers contribute with tax revenue and cheap labor, and they tend to accept low-paying jobs that no one else wants.

Data from one study on migrants, conducted by Dr. Salazar, indicated that Hispanics were of little economic burden to hospitals as well as other medical facilities because of their low utilization and their willingness to pay medical bills out-of-pocket whenever they utilized these services.

It was generally agreed that more research should be done to explore the validity of existing beliefs about migrant health behavior, health status, and how they affect the economic structure of the communities in which they live and work.

Task Force 2: The sociocultural influences on health services research and health services delivery for Hispanics

Task force leader: Margarita C. Treviño, R.N., M.S.

Task force rapporteur: Juan H. Flores, M.U.P.

Task force participants:

Juan A. Chavira, Ph.D.
Predoctoral training in family medicine curriculum development program

Madeline L. Dale, M.A.
Belief systems of the Puerto Rican and Mexican-American patient: implications for delivery of maternal and child health services

Juan H. Flores, M.U.P.
Chicano health: a perspective or alternative?

Aida Giachello, M.S.W.
Sociocultural aspects of high-risk pregnancies in a Mexican/Chicano community

Susan C. Gilman
Cultural differences in the utilization of primary health care services by urban Mexican-American elementary school children

Richard L. Hough, Ph.D.
Life change and illness: a multicultural approach

Carmen Acosta Johnson, Ph.D.
A training program for primary health care workers in contact with breast-feeding mothers

Angel Martinez
Hispanic adolescents and their families in the U.S.

John M. McCurtis, Ph.D.
Socio-structural characteristics of cervical cancer patients who fail to follow-up therapy

Antonio S. Medina, M.D.
Hispanic reproductive health in California, 1976–1977

Miriam Orleans, Ph.D.
Generational differences in the views of health status and need for service of Mexican-American elderly

Robert E. Roberts, Ph.D.
Observations on health related behavior of Mexican-Americans

larry Scherwitz, Ph.D.
The effect of language on physician-patient interaction

Antonio Zavaleta, Ph.D.
Sociocultural factors affecting Mexican-American health status and health care delivery systems in the lower Rio Grande

The purpose of Task Force 2 was to present and discuss the sociocultural influences on health services research and health services delivery for Hispanics. The charge was to develop researchable items correspondent to the expressed needs, problems, and concerns as would be appropriate for priority consideration on a research agenda of Hispanics for the 1980s and beyond.

The needs, interests, concerns, and related recommendations presented under the heading of sociocultural influences on health services research and health services delivery for Hispanics fell under three headings: (1) the use or non-use of health services; (2) strategies for resource development, including a specific focus on manpower training; and (3) policy and programs.

The types of problems presented were varied in nature as well as in their degree of definitiveness.

Task Force 2 focused on the problems of research efforts that failed to take into account the heterogenous nature of the Hispanic population. Secondary themes included the lack of data bases regarding Hispanics and some of the special needs of specific population groups, such as mothers and infants, the Hispanic adolescent, and the Hispanic elderly. Emphasis was also placed on the need for resource development, particularly manpower development and placement. There was some overlap with other task force topics such as policy and programs as well as resource development.

Task force recommendations

Task Force 2's recommendations can be summarized as follows:

Implications for Health Services Research of Hispanics

(1) Develop culturally-sensitive investigative tools which are congruent in their application to the cultural milieu of the population under study;

(2) Expand baseline information on the health and illness behaviors of Hispanics;

(3) Examine the relative effects of socioeconomic, demographic, cultural and delivery system factors on the use of medical services (particularly preventive health services);

(4) Develop comparative investigative approaches which allow for the examination of intra- and inter-Hispanic group differentials.

Implications for Health Services Delivery of Hispanics

(1) Develop client-and-family centered intervention modalities which integrate the cultural identity of the Hispanic consumer;

(2) Expand the training of Hispanic health providers at all professional and non-professional levels;

(3) Establish and develop urban and rural health initiative programs which are accessible, appropriate and acceptable to the Hispanic population;

(4) Train non-Hispanic health care providers;

(5) Establish and develop improved pregnancy outcome programs in areas heavily populated by Hispanics;

(6) Establish and develop programs for adolescent pregnancy prevention and services to the Hispanic people;

(7) Include a strong family planning component as an integral part of all such health services;

(8) Provide counseling on the implications of parenthood among all Hispanic age groups, including genetic counseling, prenatal diagnosis of congenital conditions, nutrition and supplemental food programs. Counseling concepts must involve the family as a whole, and the cultural traditions of the Hispanic family;

(9) Maximize use of mass communication media, including press, radio and television, to reach as large a Hispanic population as possible;

(10) Examine the impact of a very young and fast-growing population in Latin America on the Hispanic population in the U.S.;

(11) Secure information on the knowledge, attitudes, and opinions of Hispanic children and youth *re:* sex, sexuality, parenting, and general health issues;

(12) Focus more research on the need for social or human service support among people for whom the natural support of family members is declining;

(13) Churches should provide avenues for data and for educational leadership;

(14) Programs such as the New Futures Schools in Albuquerque, where Hispanics represent more than one-half of the enrolled population, must be adequately evaluated so that they might serve as planning models for similar ventures in areas of high Hispanic population;

(15) Deploy National Health Service Corps Hispanic health providers in areas heavily populated by Hispanics;

(16) Provide early and continuous prenatal care to undocumented women who are denied such services because of their legal status;

(17) Initiate a training program for primary health care workers on both sides of the Mexico-U.S. border which includes pre-natal, in-hospital, postnatal and at-home service activities, and includes parteras, grandmothers, others as interested;

(18) Evaluate infectious disease (especially diarrhea) on both sides of the border and in central cities such as Houston before and after promotion of breast feeding. Evaluate growth and development of breast-fed infants;

(19) Research patterns of breast feeding and judicious use of supplemental feedings because supplemental feedings for a mother may be critical to her infant, and failure of the milk supply is a reality. It must be carefully managed.

The following recommendations were made regarding policy and programs:

(1) Develop and effectuate a national Hispanic strategy to enable intervention in the initial development, refinement (negotiation and compromise), and implementation of health legislation.

(2) Determine by geographic areas with high Hispanic concentration the monetary allocations of DHHS health dollars by programs and assess the degree of available health dollars to Hispanic service deliverers.

(3) Health agencies and institutions which provide health dollars should provide mechanisms to develop management and research training support programs for Hispanics currently employed in service delivery organizations.

(4) Evaluate current DHHS health policies and programs in light of the socioeconomic and health status realities of the Hispanic population, particularly such programs as Medicaid, health manpower strategies, implementation of Health Systems Agencies and PHS-Health Services Administration health programs.

Items for a Health Services Research Agenda of Hispanics for the 1980s and Beyond

The issues revolving around the heterogeneity of Hispanics can be addressed by the development of a strategy which would lend itself to a systematic determination of *who we are*. This calls for the development of a series of baseline studies with significant numbers distributed about the country. These studies would assist in the development of a basis for comparisons inter-and-intra ethnically and hypotheses for further study. Some surveys could be carried out at the national level. Other studies could be carried out at the state or the local level.

The National Center for Health Services Research as well as the National Center for Health Statistics could monitor and support efforts to conduct baseline studies by helping to improve methodologies for statistical, epidemiological, bio-demographic, economic, and sociocultural measurements of health and illness of Hispanics.

Baseline survey research in bio-demography could address health status data and demographic parameters. In relation to Hispanics, the following items need to be investigated with the procurement of data from individuals and groups over given periods of time:

Health Status Data

Fertility rates
Birth rates
Life expectancy rates
Morbidity and mortality rates
Disability rates
Data on social pathology
  Alcoholism
  Drug Abuse
  Others

Demographic Data

Country of birth
Country of origin
Population size
Age distribution
Sex distribution
Population density
Economic status
Occupation
Employment status
Sources of income
Marital status
Level of formal education
Heads of households
Geographic boundaries

Lifestyle: Cultural Dimensions

Cultural heritage and traditions
Number of generations in the United States
Patterns of in- and- out migration
Patterns of socialization
Communication and leadership systems
Language/s spoken, written, read
Language preference for speaking, writing, reading
Family roles and functions
Personal, family, community value systems
Religious beliefs and practices
Involvement with major community systems
Attitudes towards self and others
Personal, family, and community support systems
Coping mechanisms
Perceptions of health
Perceptions of illness
Health practices
Nutritional patterns
Dietary habits

Baseline information is also needed in the area of environmental influences on the health status of Hispanics. Investigative efforts are needed in the study of environmental sanitation, waste disposal services, the status of housing, the availability of public utilities, modes of transportation, cost of transportation, land usage patterns, and the environmental conditions of the work place.

Research items that could aid the development of baseline information with reference to the health service delivery system may include the following parameters:

Availability
Accessability (social and geographic)
Adequacy
Appropriatenesses
Effectiveness
Efficiency
Continuity
Comprehensiveness
Service cost to client
Payment mechanisms
Insurance coverage
Outreach
Casefinding
Information and referral
Cultural sensitivity to client/s
Client utilization patterns
Agency patterns of service delivery
Provider-client relations

While the listings are not exhaustive, neither do they suggest that all parameters are applicable in every situation nor should they be undertaken at the same time in any investigative effort. They are intended to reflect some of the basic questions that need answers in understanding the challenge to characterize the differences and similarities of Hispanics among themselves as well as in relation to other population groups. This type of inquiry can facilitate a better understanding of the prevalence of health problems, related behaviors, and outcomes. The organization, delivery, and financing of health care of Hispanics will then stand a better chance of being more effective.

Madeleine L. Dale, M.A.

Belief systems of the Puerto Rican and the Mexican-American patient: implications for the delivery of maternal and child health services

Based on four case studies of Puerto Rican and Mexican-American families, the focus of this study was to create an awareness among health professionals of the nature of the patient's concepts of health and illness in order to understand the patient's presentation, behavior and expectations, and to encourage the patient to participate actively in health care.

The presenter stressed that an understanding of the literal and affective meaning of illness for the patient is critical. Recognition of the individual's belief systems fosters patient participation and cooperation in care and allows for negotiation when the two systems clash.

In brief, there is a need to tailor research to fit the cultural identity and sensitivity of the patient.

Aida Giachello, M.S.W.

Sociocultural aspects of high-risk pregnancies in a Mexican-Chicano community

Some of the findings of this study were:

1. The percentage of pregnant women with a high-risk condition is slightly higher than for the city as a whole.
2. The peri natal mortality for current pregnancies of the women in the sample was considerably lower than for the Mexican community or the city of Chicago as a whole.
3. The sample population had a high perinatal mortality for previous pregnancies.
4. Among the high-risk sample, previous fetal, as well as neo- and post-natal deaths were higher in comparison to the low-risk sample.
5. Most of the previous pregnancy outcomes among the sample occurred in Mexico.
6. Most of the Mexican women in the sample went for prenatal care in the second and third trimester.
7. The most frequent reasons for high-risk designation among the sample were: c-section, multipara (more than 6 children), juvenile pregnancy, and taxoplasmosis.

One issue raised during the discussion was the problem in reporting infant mortality. For example, stillbirth is sometimes included as infant mortality. Reporting might differ among groups compared in this paper.

Susan C. Gilman

Cultural differences in the utilization of primary health care services by urban Mexican-American elementary school children

This study examined possible differences between Anglos and Mexican-Americans in the use of school and community health services and possible sub-cultural differences in the use of services within the Mexican-American group.

Two unobtrusive measures were used to ascertain the degree of acculturation of the Mexican-American children and their parents: the return of the questionnaire in Spanish; and the enrollment of the child in the elementary school bilingual class.

No statistically significant differences were found between the two groups with respect to whether or not they made any visits to a source of health care. Twice as many Mexican-American as Anglo children did not visit a health care source in or outside of school. No significant differences were found in the number of visits for health services within the Mexican-American group. Mexican-American and Anglo children did not differ in the type of health problems presented, except fewer Mexican-American children made visits for behavioral or emotional problems.

The results indicate that when health services are available and accessible and when barriers such as income and language are minimized, Mexican-American and Anglo children do not differ in their use of health services in school or in the community.

Discussion stressed the problems involved in assuming that the Spanish-speaking also read Spanish, as well as the need to recognize the heterogeneous characteristics of the Spanish language.

Richard L. Hough, Ph.D.

Life change and illness: a multicultural approach

The Life Change and Illness Research Project at the University of California, Los Angeles, is a study concerning stress and physical and psychiatric impairment among residents of El Paso, Texas and Ciudad Juarez, Chihuahua, Mexico.

The study sample consisted of residents from both border communities between the ages of 21 to 60 who were members of four dominant cultural-residential groups: Anglos, Mexican-Americans, Mexicans living in El Paso, and Mexicans living in Ciudad Juarez. Respondents from El Paso were selected through a random sampling procedure. Respondents from Ciudad Juarez were selected through a multi-stage cluster sample.

According to the researchers, the most important finding in relation to health care utilization was the number of people who did not report seeking health care from the sources listed in the research instrument. The highest mean number of physical illness symptoms were reported by Mexicans in Juarez, and they were also more likely to forego seeking care than any other group. Of the total sample (N=90), 19.4 percent reported "no care" from any source that was identified by the researchers, e.g., the traditional "western" sources such as physicians, pharmacists, and osteopaths and other resources such as priests, herbmen, curanderos, spiritualists and midwives.

A methodological limitation acknowledged by the researchers was that their instrument may not have included several other significant sources on health care, such as family and friends.

An estimate was also made of the effects of a number of demographic, family, socioeconomic and subjective illness measures on health resource usage. Ethnicity, number of physical symptoms, and the number of household responsibilities were the only three variables which contributed to the significance of the prediction models. Of these, ethnicity was the most important predictor.

Mexicans in Jaurez were most likely to forego care, while the Anglos tended to mix western sources with auxiliary care providers of all types. The Mexican-Americans and Mexicans in El Paso were most likely to see only western practioners, with the latter least likely to be mixers. Mexicans in El Paso visited M.D.s for treatment of their illnesses or they received no care at all (from the sources tapped by the research instrument).

The analysis of physical symptom reporting showed a mean number of symptoms reported by Anglos ($\bar{x}$ = 12) as being quite similar to that of Juarencians ($\bar{x}$ = 12.5). Mexican-Americans had a mean number of symptoms reported of ($\bar{x}$ = 9.7), and Mexicans in El Paso reported a significantly lower number of symptoms ($\bar{x}$ = 8.1).

The number of physical illness symptoms did vary across cultural-residential groups. Instead of finding an expected linear pattern of high symptom reporting by Juarencians to low reporting by Anglos, the evidence suggests that the "marginal" Mexican-Americans and Mexicans in El Paso report and/or experience fewer symptoms. Being marginal was defined as living between two distinct cultures.

The hypothesis that Mexican-Americans and Mexicans in El Paso might be a healthier group was entertained. However, it is not justifiable if the traditional epidemiological indicators such as infant mortality, rates of Tb, low birth weights, and life expectancy were taken into account. The Spanish-surnamed in El Paso, as in Texas, do not fare as well as Anglos in all of these measures.

The recommendations were as follows:

(1) Life change and stress events must be examined within the cultural context in which they occur and should not be given equal weight cross-culturally;

(2) Care must be given to the development of measurement scales cross-culturally and to the use of multi-variate modes of analysis with the use of surveys and epidemiological methods;

(3) There is a need to understand who the health care providers are since this relates to health resource use and non-use.

Carmen Acosta Johnson, Ph.D.

A training program for primary health care workers in contact with breast-feeding mothers

This study reviewed the patterns of differentials associated with breast-feeding and defined a strategy to improve this aspect of maternal and child health. The strategy consisted of a comprehensive training program for primary health care workers in contact with breast-feeding mothers at each stage in the lactation period.

Observing the high infant mortality and morbidity rates in Hispanic communities—rates that cannot be explained by poor weight at birth—it is likely that infant health could be considerably improved by encouraging breast-feeding. At present, Hispanic communities have one of the lowest levels of mothers who choose to breast feed and one of the highest levels of failure among those same mothers.

A strategy recognized by the World Health Organization as being universally acceptable

and effective is that of training primary health care workers in the needed skills to support the provision of human milk for Hispanic infants. The following recommendations were submitted by the speaker:

(1) a training program for primary health care workers on both sides of the Mexico-U.S. border which would include prenatal, in-hospital, postnatal and at-home service activities;

(2) Evaluate infectious disease (especially diarrhea) on both sides of the border and in central cities such as Houston before and after promotion of breast feeding; evaluate growth and development of breast-fed infants; and

(3) Research patterns of breast feeding and judicious use of supplemental feedings because supplemental feedings by a mother may be critical to her infant, and failure of the milk supply is a reality which must be carefully managed.

Angel Martinez

Hispanic adolescents and their families in the U.S.

This position paper discussed seven major issues relevant to the Hispanic adolescent and his family in the United States.

The presentation included a brief description of the various categories of Hispanic adolescents, their numbers, and available data and programs.

With reference to traditions and pressures, some of the conflict of values encountered by Hispanic adolescents and their families in the United States were explored. Stereotypes were also addressed, with emphasis on the role of the media in projected perceptions of adolescents in the United States.

Family relations were presented through vignettes which raised some of the issues that Hispanics face when an adolescent pregnancy occurs. Educational concerns focused on drop-out rates, educational opportunities and job problems as a result of low education among Hispanic adolescents. The discussion addressed teenage sexuality, U.S. society, mass media and the moral conflicts that these institutions often provoke.

The following recommendations were made:

(1) We must strive to understand the impact of a very young and fast-growing population in Latin America on the Hispanic population in the United States;

(2) We must secure information on the knowledge, attitudes, and opinions of Hispanic children and youth about sex, sexuality, parenting, and general health issues;

(3) We must make policy studies that accurately reflect the effect of minimum wage laws and tax incentive initiatives on Hispanics. Through these, manpower plans can be developed which deal with the group that has the highest unemployment rate—youth;

(4) We must improve access to health careers for Hispanics;

(5) Churches should provide avenues for data and for educational leadership; and

(6) Programs such as the New Futures School in Albuquerque, where Hispanics represent more than one-half of the enrolled population, must be adequately evaluated so that they might serve as planning models for similar ventures in areas of high Hispanic population.

Antonio S. Medina, M.D., M.P.H.

Hispanic reproductive health in California, 1976-1977

The intent of the presentation was to portray the perinatal and reproductive health status of Hispanic women in California as compared to other ethnic groups through selected information.

The study was based on selected data concerning reproductive health behavior and pregnancy outcomes by ethnic group for the State of California Birth Cohorts in 1976 and 1977. The objectives of the study were to identify gaps in the reproductive health among the Hispanics and the Anglo-Saxons and to identify areas of intervention to address the gaps.

The findings of the study were:

(1) Prenatal care among Hispanic women was characterized by late onset or complete absence of care compared with other ethnic groups;

(2) Fetal death ratios increased among Hispanics when they had late onset or no prenatal care;

(3) When compared to other ethnic groups, fetal death ratios were considerably higher for Hispanics when the onset of prenatal care was during the third trimester of pregnancy or prenatal care was never provided;

(4) Data for the 24 selected counties showed higher fetal death ratios for Hispanics when compared to Anglo-Saxons. There was a suggested relationship between heavily populated areas and fetal death ratios for Hispanics. The black population showed the highest fetal death ratios among all ethnic groups;

(5) For 1976, Alameda County data revealed no significant differences in pregnancy outcomes for Hispanics and for Anglo-Saxons. The

blacks showed considerably higher undersirable pregnancy outcomes than Hispanics and Anglo-Saxons. The "other" ethnic group has considerably better pregnancy outcomes than Hispanics and Anglo-Saxons;

(6) Data from the Natividad Medical Center revealed that in 1976 all nine fetal deaths occurred among Hispanic women; in 1977, three out of the six fetal deaths occurred among Hispanics. When compared in terms of absolute figures, the fetal death ratios for Hispanics were reduced fourfold in 1977;

(7) In terms of reproductive behavior, the California birth cohort 1977 data were analyzed in relation to birth rates by age of mother, total number of children born, and ethnic group. The birth rate for Hispanic mothers under 15 years of age was three times as high as that of the Anglo-Saxons and of the "others" and was about one half that of the blacks; for Hispanic mothers under the age of 20, it was almost twice as high as that of the Anglo-Saxons and more than twice as high as that of "others," but 80 percent that of the blacks; for Hispanic mothers 35 years and older, the birth rate was somewhat higher than those of Anglo-Saxons, and about 170 percent that of blacks, but only 70 percent of "other." The data showed that the ratio for Hispanic women over 40 years of age with four or more children was about 80 percent as high as that of the Anglo-Saxons and 66 percent as high as that of the blacks. The "others" had a birth rate 110 percent that of the Hispanics.

According to the study, the majority of Hispanic women in the State of California receive late or no prenatal care. Influential factors were identified as: (1) a lack of awareness of prenatal care services and their significance on the outcome of pregnancy; (2) a lack of motivation to utilize the services; (3) ineligibility or inaccessibility to the services; and (4) a shortage of Hispanic health providers. These factors appear to contribute to the frequency of undesirable outcomes of pregnancy among Hispanics.

The recommendations were as follows:

(1) Expand the training of Hispanic health providers at all professional and non-professional levels;

(2) Establish and develop improved pregnancy outcome programs in areas heavily populated by Hispanics;

(3) Establish and develop urban and rural health initiative programs which are accessible, appropriate and acceptable to the Hispanic population;

(4) Establish and develop programs for adolescent pregnancy prevention and services to the Hispanic people;

(5) Include a strong family planning component as an integral part of all such health services;

(6) Provide counseling on the implications of parenthood among all Hispanic age groups, including genetic counseling, prenatal diagnosis of congenital conditions, nutrition and supplemental food programs. Counseling concepts must involve the family as a whole and the cultural tradition of the life style of the Hispanic family;

(7) Maximize use of mass communication media, including press, radio and television, to reach as large a Hispanic population as possible.

(8) Deploy Hispanic National Health Service Corps providers in areas heavily populated by Hispanics; and

(9) Provide early and continuous prenatal care to undocumented women who are denied such services because of their legal status.

Miriam Orleans, Ph.D.

Generational differences in the views of health status and need for service of Mexican-American elderly

The intent of this study was to consider similarities and differences among older people at each site (Denver, Greeley, and in the rural area surrounding two small communities of Johnstown and Milliken, Colorado) with respect to their self-reported health status, their independence, their financial status, their social and economic resources, and their use of health and social services.

After finding that some of the respondents resided with their adult children, a sub-study was conducted to examine the children's attitudes and views to see whether their perceptions agreed with those of their previously interviewed parents regarding well-being, problems, needs, and use of services. Children's views of the viability of their parents may be critical ones when decisions are made as to the future of the elderly. Their views of needs may be the only ones expressed as demands for services, according to the report. Their views may be considered as being more determinant of the quality of life of their parents than those of the elderly themselves.

Telephone interviews were conducted to survey a sub-total of 62 respondents. The forms of the questions were identical with those of the main study. The following areas were covered:

(1) views of health and illness;

(2) use of medical care: its quality, ease of access, and means of financing;

(3) personal care and housekeeping tasks;

(4) out-of-home activities and participation in community organizations;

(5) transportation and general mobility;

(6) visiting and phone contact with family and friends; and

(7) attitudes toward living arrangements, including nursing homes.

Most of the respondents were urban: 45 were from Denver, eight from Greeley, and eight from the Johnstown-Milliken area. Thirty-three men and 29 women were interviewed. Two-thirds of the respondents were single. All but one were English-speaking.

More children described their parents as feeling healthy than did the older people themselves, but the differences were not significant. When questioned about illness, there were significant differences in the reports. The parents mentioned musculoskeletal disorders most often. The children mentioned heart disease and hypertension.

In terms of the use of medical care—its quality, ease of access, and means of financing—all the respondents said that the parents saw private doctors most often, but parents reported more visits to clinics and more taking care of health problems themselves than their children did.

Seventy-one percent of the parents said that they were pleased with their medical care, while only 54 percent of their children said this. Over three-fourths of each respondent group said it was easy to get care. About 25 percent said they had financial difficulties, but the anticipation that access problems and cultural barriers deprived the elderly of care was not borne out in this sub-study, just as they had not been revealed in the large study.

In the area of personal care and housekeeping tasks, parents generally reported less of a need for assistance than their children believed they required. Discrepancies in this area are of interest because they are potential indicators of differing views of the viability of the parents.

In relation to transportation and general mobility, more parents said they drove or took the bus than was reported by the children. Some parents would like to be more mobile than their children believe. They would like to go shopping more often and visit their children more than they do. In general, most parents indicated that they go out as often as they needed to and had no interest in getting out more.

In examining attitudes toward living arrangements, including nursing homes, the predominant choice among parents and children was to live at home with someone living in and helping. Nursing homes were not seen as likely future residences for parents by either group.

The presenter suggested that the findings indicate the need for more extensive inquiry into the nature and amount of support needed when children are not present. Emphasis was placed on the need to discover the amount of need for social or human service support among people for whom the natural support of family members is declining.

Attention was also given to the differences in reporting the status of the elderly to warrant more systematic studies. There is a need to explore means to facilitate the maintenance of the elderly in their homes.

Robert E. Roberts, Ph.D.

Observations on health-related behavior of Mexican-Americans

One of the purposes of this paper was to provide more data on the health and illness behavior of Mexican-Americans. The state of the art was documented by noting that, while Mexican-Americans constitute a distinct demographic and cultural population group and also comprise the largest ethnic minority in the Southwest and one of the largest minorities in America, health data on this segment of American society are virtually nonexistent.

The data for this presentation were the results of secondary analysis of data from health surveys conducted as part of the ongoing research programs of the Human Population Laboratory, California State Department of Health Services. The studies, which included Mexican-American respondents, were conceived and designed as general purpose health surveys, emphasizing health status and its correlates. Limited data were also collected on use of medical services and on discretionary health practices relating to diet, smoking, exercise, etc.

For physician visits, Chicanos reported the lowest rate, although ethnic differences overall were small. Chicanos also reported the lowest rate of general medical examinations. Both minority groups reported low rates of dental examinations, with the rate for Chicanos markedly lower than for Anglos, but higher than for blacks. Chicanos reported much lower rates of eye examinations than either Anglos or blacks. Chicanos in Alameda County also reported generally lower rates of discretionary health practices than Anglos.

In concluding, the author stated that:

(1) There is a need for more data, even of a descriptive nature, on the health and illness behavior of Mexican-Americans;

(2) Research is needed which examines the relative effects of socioeconomic, demographic, cultural and delivery system factors on use of medical services; and

(3) Research should employ a comparative approach, examining health and illness behavior of Mexican-Americans in different community contexts (including rural/urban and regional variations) as well as comparing medical care of Mexican-Americans with other Hispanic groups such as Puerto Ricans and Cubans. Such comparative research will require more rigorous approaches to the conceptualization and measurement of ethnicity if the effects of this variable are to be disentangled from the others.

Larry Scherwitz, Ph.D.

The effect of language on physician-patient interaction

To assess whether information given to patients differed in English or Spanish, the researchers recorded 22 visits by hypertensive patients to one bilingual physician at a community health center. At 13 of these visits, Spanish was spoken; the remaining nine were conducted in English. The transcripts were scored for medicine-related instructions; monitoring about current use of medications; and use of motivating strategies (authority and justification). Comparison of the two groups on these factors revealed a consistent trend: in Spanish, the physician instructed and monitored more and showed a greater use of authority and justification. The Spanish-speaking patients were prescribed more new medications and had more medicines stopped or changed in dosage or schedule than the English-speaking patients, accounting for the differences in information presented.

Antonio Zavaleta, Ph.D.

Sociocultural factors affecting Mexican-American health status and health care delivery systems in the lower Rio Grande valley of Texas

Conducted in the southernmost tip of Texas on the border with Mexico, this study was designed to examine the cultural and socioeconomic health practices that directly influence Mexican-American health status.

The first phases of this study focus on maternal and child health, and a complete set of demographic indicators are included in the data. The study proposed to utilize the data for the development of improved health care services and health education programs at the grassroots level.

Task Force 3: Resource development strategies for conducting health services research among Hispanic populations

Task force leader: Pedro Lecca, Ph.D.

Task force rapporteur: Ernest Fuentes, M.S.S.W.

Task force participants:

Marilyn Aguirre, M.S.
Alcoholism counselor training requirements for intervention with the Puerto Rican client

Emil Berkanovic, Ph.D.
The effect of language of the interview on responses to surveys aimed at predicting the use of health services

Robert Buechley, Ph.D.
Actually doing Hispanic health research: a 25-year perspective

Mary L. Durham, Ph.D.
Health resource networks: a multi-cultural approach

Daniel J. Erickson, M.D.
The Chicano version of the sickness impact profile: a translated health status measure with broad applicability to Hispanics

Lynn Evans, Ph.D.
A comparative study of Mexican-American and black hypertensive patients in a community health center

Leroy Martinez, M.Ed.
Assessment of bilingual and bicultural awareness activies in health professional schools

Raymond F. Martinez
A cross-cultural study of alcohol use

Lydia Mendoza, M.S.
Non-kin support networks of the Hispano/Mexicano elderly: implications for health services research and delivery

Carlos Molina, Ed.D.
Development of content areas for a health curriculum for New York College Puerto Rican students

Ruben D. Rumbaut, M.D.
Hispanic psychiatrists in the U.S.

David J. Sanchez, Jr., Ph.D.
Hispanic health policy issues: fragmentation or collaboration?

The end of this decade will see the health industry exceed $180 billion in expenditures, and the technology far exceed what was imagined ten years ago. Although resource development has had dramatic impact on health services research, we now know that Hispanic health services research and data are severely deficient. The following recommendations of Task Force 3 suggest ways to fill gaps in health services research in order to expedite resource development for Hispanics in America. Papers in this category are in four major areas:

I. Implications of language and its effect on the utilization of health services

Daniel J. Erickson, M.D.
The Chicano version of the sickness impact profile: A translated health status measure with broad applicability to Hispanics.

Purpose: To establish a better understanding of the difficulties involved in translations, and to establish a measure with broad applicability to Hispanics.

Findings: The translation of the *Sickness Impact Profile* into Chicano Spanish provides English-Chicano versions that are meaningful equivalents. This allows for translations applicable to other Hispanic groups.

Emil Berkanovic, Ph.D.,
The effect of the language of the interview on responses to surveys aimed at predicting the use of health services.

Purpose: A study of the effects of translations of information used in interviews concerning health services delivery.

Methodology: In a survey of 1,210 persons in the Los Angeles area, 207 of whom were Hispanic, 87 were interviewed in Spanish.

Findings: People generally understood the survey, but were amused by some of the questions and by the Spanish used, which was not idiomatic to this group.

Recommendations: (1) Use language idiomatic to the community in designing questionnaires, surveys, and research materials; (2) Pre-test interviews should be conducted in the community to solicit opinions on the materials to be used; (3) The community being interviewed should routinely be provided information on the data obtained.

Discussion: Comments were generally favorable when the research effort involved the community being examined. The group, however, was very much against research that used translations which were inappropriate for the community being examined.

II. The development and replication of specific measurement tools to quantify utilization of health services

Raymond F. Martinez

A cross-cultural study of alcohol use

Purpose: To arrive at a better understanding of alcoholism in the Chicano population.

Methodology: "Nominal Group Technique" (NGT) as a process of identifying and prioritizing a large number of problems in a short period of time.

Findings: Mexican-American respondents experience more serious problems from alcohol use than their Anglo counterparts.

Recommendations: The use of the NGT provides a quick and economical means of obtaining data. Some of the advantages are: (1) The technique requires fewer staff and less supplies than other methods; (2) Data can be collected easily in a short period of time; (3) The technique can generate the interest and encourage the involvement of community members, which will help develop credibility for program implementation; (4) When samples are matched, NGT can provide relevant and valid data.

Marilyn Aguirre, M.S.

Alcoholism counselor training requirements for intervention with the Puerto Rican client

Purpose: To provide appropriate training to alcoholism personnel who work with special populations.

Methodology: Use of the "Critical Incident Technique" in investigating an area where a large body of knowledge does not exist.

Findings: (1) Needs of the individual socio-cultural and socio-economic dynamics must be assessed in order to determine how they impact on the problems of alcoholic Puerto Ricans; (2) There is a shortage of personnel having the skill, knowledge, and language ability to work with Puerto Ricans and other Hispanics; (3) Alcoholism services are fragmented, uncoordinated, and inaccessible; (4) Research must not continue in a vacuum. There needs to be an awareness of individual needs in special populations, an increase of trained personnel familiar with special population needs, and coordination of services directed to special populations.

Carlos Molina, Ed.D.

Development of content areas for a health curriculum for Puerto Rican students in the City College of New York

Purpose: Identification of appropriate content areas for the health education curriculum for Puerto Rican students in the City College of New York.

Methodology: Delphi technique

Findings: The health education curriculum was classified, ranked, and prioritized; the Delphi technique was found successful in developing a curriculum particular to one specific group.

Mary Durham, Ph.D.

Health resource networks: a multi-cultural approach

Purpose: An overview of methodological developments involved in cross-cultural research.

Methodology: Observations of different methodological approaches.

Findings: (1) Research and research utilization is too involved in: "western biases"; (2) Further analysis of non-use of medical and health services is necessary; (3) There is a need for innovative approaches to research based mainly on the specific population being examined; and (4) There is a need for further examination and assessment of needs of medical and health care services use or non-use.

Recommendations: (1) Further use and replication of the Nominal Group Technique, which has these advantages of economy of staff and supplies, ease of data collection in a short time,

community interest and involvement, and the capability to provide relevant and valid data. (2) Further use and replication of the Critical Incident Technique, which has the advantages of awareness of individual needs in the group being examined, use of trained personnel who are knowledgeable of the group being examined, and coordination of existing and planned services directed to the population being examined.

Discussion: The participants were very interested in the different approaches of the research projects and their findings. The group believed that the use of traditional research methods was more easily supportable and more likely to attract support than experimental and innovative research.

III. Innovations in curriculum and program development and their impact on health services education

Lydia Mendoza, M.S.

Non-kin support networks of the Hispano/Mexicano elderly: implications for health services research and health services delivery

Purpose: An attempt to identify the non-kin support network in Hispano/Mexicano elderly and its characteristics and reasons for success.

Methodology: A series of studies evolved from this project. The first was a test of alternative research methods acceptable to the Chicano elderly. The second study focused on the what, how, and why of the forms of interaction that had developed.

Findings: The first study identified the *"servidores"* who had the following characteristics: *servidores communicatives*, career track, involved in organizing the outreach activities and in policy making issues; *servidores personales*, caseworkers, working on an individual client/caseworker level; *servidores de los vecinos*, caretakers, helping in a variety of supportive services yet do not interface with the human care agency.

Recommendations: (1) We must not rely on standard survey research in developing new projects; (2) participation and input by the community being examined is needed; (3) Evaluation and assessment must be disseminated and feedback sought; (4) Further examination of other supportive networks that exist in Hispanic communities is needed; (5) Incorporation of this information into curricula and training programs is required.

Leroy J. Martinez, M.Ed.

Assessment of bilingual and bicultural awareness activities in health professional schools

Purpose: An attempt to assess bilingual and bicultural awareness and its effects in the delivery of adequate health services for this specific population group.

Methodology: The research model was designed to examine the following major areas in the health professions schools: (1) The effects of sensitizing minority and non-minority students to cultural differences; (2) The effects of increasing the numbers of bilingual and bicultural students in underserved areas through recruitment, enrollment, and retention; (3) The effects of administrative and faculty sensitivity to cultural and linguistic differences; and (4) The effects of the preceeding on the delivery of acceptable health care services for bilingual and bicultural populations. An advisory group was established to provide guidance on all major aspects of the design, including analysis of the information which was acquired from this study.

Findings: There was determined to be: (1) a lack of communication with health care providers; (2) general insensitivity on the part of the providers; (3) scarcity of translators, and of bilingual signs and printed matter; (4) lack of understanding about dietary habits; and (5) inclination by providers to perform high-technology procedures when other less invasive alternatives were available, such as herbal medications, acupuncture, and other means.

Recommendations: Steps should be taken to improve future administrative actions by DHEW (now DHHS); future Congressional legislative actions; and future program action by the health professions schools. Moreover, (1) traditional standard survey research must not be used as the only guideline for the development of new program curriculum; (2) participation and community input is necessary in the development of new program curriculum; (3) program information and needs assessments must be properly disseminated to the community being examined and feedback obtained; (4) further research is needed of existing support networks found in Hispanic communities; (5) research findings should be disseminated and incorporated into curricula and training programs; (6) further research into more appropriate methods and teaching strategies relevant to specific populations is needed; and (7) research into the development of a uniform reporting system for bilingual and bicultural activities is needed.

Discussion: Most of the comments focused on the lack of understanding at the federal level of

the need for change and more cultural awareness in program development. Insensitivity appears to be the most important factor that hinders change in curricula and program development that is relevant to Hispanic populations.

Ruben Rumbaut, M.D.
Hispanic psychiatrists in the U.S.

Of the approximately 34,000 practicing psychiatrists in the U.S., 25,000 are members of the American Psychiatrics Association. Of these, about 1,075 are psychiatrists who speak Spanish and either have Spanish surnames, were born in Spanish-speaking countries, or have a strong Hispanic affinity. This paper groups Hispanic psychiatrists residing in the U.S. by national origin and raises questions about their findings. For example, why are there so many foreign medical graduates and so few continental-U.S. born graduates among Hispanic psychiatrists? Where is the bottleneck in the education of Hispanics in the U.S.? What is the relationship between Hispanic psychiatrists and their respective sectors of the population (Chicanos, Puerto Ricans, Cubans, and other Hispanics)? What are the implications for the education, training, practice and research activities of Hispanic psychiatrists in the U.S.?

IV. Mechanisms for intervention in specific disease categories

Lynn A. Evans, Ph.D.
A comparative study of Mexican-American and black hypertensive patients in a community health center

Purpose: To compare hypertension levels between Mexican-American and black patients in a community health center.

Methodology: Data collection at Casa de Amigo and three other community health centers in Harris County, Texas.

Findings: Black and Mexican American hypertensive patients had similar blood pressures, were being treated in a similar fashion, and achieved the same degree of control. In the area of specific diseases, we must make comparisons between different ethnic groups to see if there are any differences that may be particular to one ethnic group.

Robert W. Buechley, Ph.D.
Actually doing Hispanic health research: a 25-year perspective

Purpose: A 25-year study of cancer rates across the country among Hispanics.

Methodology: Up-dating and properly documenting information so that comparisons may be made.

Findings: (1) The census information was poorly developed; (2) there is a need for further distinction among Hispanics—Cuban American, Puerto Rican Americans, and Mexican-Americans. Improved records on Hispanics are needed, perhaps based on the register base used by hospital records.

Recommendations: (1) Continued and improved data collection and record-keeping in specific disease categories are needed for Hispanic groups; (2) comparisons of specific diseases among different ethnic groups are needed.

David J. Sanchez, Jr., Ph.D.
Hispanic health policy issues: fragmentation or collaboration?

Purpose: To put forth a position statement on the need for strengthening existing bonds among the Hispanic community. Such unity could be improved through the establishment of a national Hispanic institute.

Recommendations: (1) To establish a policy and research institute for national dissemination of information; (2) to establish training programs to assist in overcoming manpower shortages in a number of disciplines; and (3) to achieve closer analysis of institutional barriers and their impact on Hispanics. The National Hispanic Institute would offer the opportunity for collaboration from a number of disciplines, and would encourage professional understanding and trust. A leading function would be to provide a formal mechanism to help identify key, critical issues facing Hispanics. Leadership for the institute concept should come from NCHSR and NCHS.

There is considerable agreement among Hispanics that research on Hispanic populations must be conceptualized and conducted by qualified Hispanic researchers who are sensitive to bicultural and multicultural dimensions. Because of the current shortage of Hispanic researchers, it is apparent that a concentrated effort must be made to create opportunities for Hispanic professionals who are trained and interested in research, and who must be given the opportunity to conduct research. Similarly, a national effort to train new Hispanic researchers must be given top priority.

Task Force 4: Facilitation of the timely dissemination and assessment of Hispanic health services research

Task force leader: Carlos Vallbona, M.D.

Task force rapporteur: Amelie G. Ramirez, M.P.H.

Task force participants:

Rina Alcalay, Ph.D.
Perinatal care services for Hispanics: an evaluation study in South Valley, Albuquerque, New Mexico

Emile Farge, Ph.D.
Conceptions and misconceptions concerning Mexican-American health care

Maria Gonzalez
The Hispanic health council: community-based research for health systems change

Orlando Marichal, M.S.W.
The area health education program and the Hispanic community: a partnership for health systems change

Lawrence A. Perin, M.D.
Improvement of Hispanic health services delivery: a cooperative hospital-community program

Amelie G. Ramirez, M.P.H.
A methodology for alerting the Spanish-speaking community about "El Asesino Silencioso"

Dorothy M. Reno
Study of the impact of medical and management data on health services delivery to Hispanics

Vickey Reyes
USC Cancer Center Porta-pap clinic project

Miquela Rivera, M.A.
The delivery of mental health services to the Latino community: a systematic approach

Zoila Ruiz, Ph.D.
A survey of high school bilingual students in the city of New Orleans

Ruth Zambrana, Ph.D.
Research dilemmas: new directions and priorities for the Puerto Rican community

The charge to Task Force 4 was to develop a strategy for the "facilitation of the timely dissemination and assessment of Hispanic health services research." None of the papers submitted for presentation at the conference dealt with this particular issue, but after hearing and discussing the papers of members of this task force, there was ample discussion of ways and means to facilitate contact among Hispanic health service researchers and to disseminate the results of their work. Thus, it was possible to arrive at specific recommendations which will be presented later.

Task Force 4 had representation from all Hispanic groups and was composed of individuals from the East Coast (New York, Connecticut, Pennsylvania), the Midwest (Michigan), the Southwest (Texas, Louisiana) and the West Coast (California). The participants were a multidisciplinary group with varying degrees of experience in health services research. Some had already made substantial contributions to the literature, while others were primarily involved in the delivery of health services with little expertise in the research field. All of them, however, interacted effectively and were able to focus on specific research questions that arose out of the paper presentations.

The disciplines represented in the Task Force included: medicine (mainly the primary care specialties), public health, mental health, psychology, sociology, biostatistics, health care administration, computer science, community organization, communications, and education. Representatives of the National Center for Health Services Research and of the National Center for Health Statistics participated actively in the discussion of the papers and in the deliberations that led to the formulation of specific recommendations.

The papers that were presented in the afternoon session of September 6 and in the morning session of September 7 dealt with several issues and a variety of research questions which may be classified in the following categories:

(a) *Folk medicine.* What are the similarities and dissimilarities of beliefs and practices between Hispanics of Mexican, Cuban and Puerto Rican origin? Do the same beliefs hold true in urban and rural areas? Are there any commonalities in the beliefs that Hispanics in the U.S. hold as compared to those of their mother country (e.g., Puerto Ricans in the U.S. compared to Puerto Ricans in Puerto Rico)?

(b) *Health care attitudes.* What are the attitudes toward health care delivery in the various sociocultural groups of Hispanics? Are there specific health care needs that require further documentation?

(c) *Utilization of health services.* What factors lead to underutilization of health services by Hispanics? Is this underutilization the result of attitudes or barriers (i.e., language, insufficient health manpower, lack of knowledge of availability of services)?

(d) *Medical education.* Is the curriculum in medical schools and in schools of allied health professionals adequate to meet the health care needs of Hispanics? Should the curriculum stress cultural awareness about Hispanics and the health problems unique to this population? What have been the results of medical school efforts to recruit Hispanic students?

(e) *Health care data.* Should a standardized procedure for Hispanic health data collection be developed? What type of periodic reports are needed to monitor health utilization by Hispanics?

(f) *Media.* What is the effectiveness of the various media in disseminating health information to the Hispanic community? Are there strategies equally effective for Hispanics in the U.S. and for Hispanics of other Spanish-speaking countries?

(g) *Mental health.* What strategies can be employed to collect data regarding the mental health needs of adolescents? What are the attitudes of Hispanics towards their elders? What is the coping behavior of the Hispanic aged population?

(h) *Prenatal care.* What are the attitudes of Hispanic women toward family planning? Do their religious beliefs influence these attitudes? Is sterilization overutilized in Hispanic women? What are the attitudes of pregnant women toward the quality of prenatal care services?

As a result of its deliberations, Task Force 4 recommends:

1. *The establishment of formal mechanisms for the dissemination of research results.* The task force recognizes the need to preserve the researcher's initiative in utilizing existing avenues for formal presentations of work at research meetings and for publication in well edited and reputable journals. However, the task force recognized the need to establish a collective initiative to facilitate presentation of Hispanic health services research data. Appropriate mechanisms would be:

(a) National meetings for the specific purpose of presenting Hispanic health services research data and special sessions within already established national meetings where health services researchers interact (e.g., meetings of the American Public Health Association, Operations Research Society of America, American Hospital Association, Clinical Research Society). As the activity in this field increases, the need may arise for regional meetings.

(b) Publication of a national journal and special issues in existing journals. Although the existing journals provide an open forum to report the results of high quality Hispanic health services research, the members of the task force feel that the existence of a well refereed, high quality journal may provide additional incentive to Hispanic researchers not only of the U.S. but of other Spanish-speaking countries. If such a journal is established, it should be bilingual—that is, all articles should be published in Spanish and English.

2. *The establishment of a national resource to promote health services research.* The task force gave considerable attention to the possibility of establishing a national association of Hispanic health service researchers. Specific activities of this association would be:

(a) To provide a clearinghouse of information on health statistics about Hispanics or grant awards in health services research on theses and articles.

(b) To publish a newsletter.

(c) To organize consulting teams to function as a resource to students, researchers and users of health services research data. These teams could also assist in the assessment of the quality of Hispanic health services research.

(d) To establish a policy panel (of researchers and users) that would assist the National Center for Health Services Research and the National Center for Health Statistics in formulating research initiatives, priorities and implementation plans. The panel would also help in transferring research findings to the area of health services delivery.

An alternative to the national organization would be the establishment of a Hispanic Health

Services Research Center in an academic institution in a manner similar to the existing Health Care Technology Research Center.

An important stimulus to Hispanic health services research may be the establishment of an annual award for the best health service research activity which holds promise of having a favorable impact on the health status of Hispanics.

3. *The establishment of a mechanism for international cooperation with health services researchers of all Spanish-speaking countries.* Such cooperation would be in the areas of:

(a) Training
(b) National health surveys
(c) Exchange of scholars
(d) International meetings
(e) Recognition of degrees granted to health manpower workers.

The Pan American Health Organization may be the catalyst for the promotion of cooperative efforts.

4. *The establishment of a national structure for coordination of Hispanic health services research.* The task force recognizes that it would be premature to recommend the establishment of a separate structure for the promotion and monitoring of Hispanic health services research. However, the task force members favor the creation of a special division of Hispanic Health Concerns in the office of the Deputy Assistant Secretary for Health Services Research, Statistics, and Technology. The proposed division could do much to initiate all the activities previously mentioned and could provide the liaison between the government and a university-based health services research center and/or a national association for Hispanic health services research.

Emile Farge, Ph.D.

Conceptions and misconceptions concerning Mexican-American health care

The hypothesis that Mexican-Americans who are younger and who have more contact with Anglos will have a more scientific health orientation was unconfirmed in this study. Likewise, the hypothesis that "good health depends on good luck" was not confirmed by a majority, with 59.7 percent of those surveyed expressing disagreement. The highest income groups were the least convinced that good luck determines health (18.4 percent), and the lowest income groups were most convinced (63.3 percent). Finally, the notion of near unanimous belief in folk diseases and folk cures among Mexican-Americans was also unconfirmed, with only 35 percent responding "yes" to such questions. In this study, two other hypotheses were also unconfirmed: that resistance to Anglicization is an obstacle to the acceptance of scientific health care and that Mexican-Americans identify more with folk healers than medical doctors.

The author concluded that there is no single "Mexican-American model" of health care behavior. There is, rather, a continuum which runs from very non-scientific ("folk") to scientific.

Lawrence Perin, M.D.

Improvement of Hispanic health services delivery: a cooperative hospital-community program

Based in Allentown, Pennsylvania, this project dealt with an Hispanic minority population for which there has been a scarcity of social and medical services. An evolutionary approach attacking the underlying communication barriers at the root of these problems was developed to promote an awareness within the non-Hispanic hospital provider population, with institutional and personal changes in attitude as the main goal. Through a coordinated effort by hospital and community personnel, a symposium was held which addressed the language problem and outlined goals that were eventually implemented. As an outgrowth of this effort, a community-based clinical site integrating comprehensive, team-oriented care was developed with local funds. Cooperating agencies included Casa Guadalupe, an Hispanic services center, and Public Health Nursing Service, a home health agency. Close affiliation was maintained with the University of Pennsylvania, and a graduate program for family nurse clinicians was an essential part of the project. An ongoing data base is being developed to provide epidemiological and health care economic research information.

Amelie G. Ramirez, M.P.H.

A methodology for alerting the Spanish-speaking community about "El Asesino Silencioso"

Few studies have attempted to document the prevalence of hypertension or other cardiovascular diseases in the Hispanic population. However, before any large-scale intervention to determine the prevalence of hypertension is initiated, preliminary questions concerning how to reach and motivate this population to adopt risk-reducing cardiovascular health behaviors should be answered. Results of a community

survey conducted in Houston, Texas, indicate that creating awareness of high blood pressure and other cardiovascular risks is the first step. This survey revealed that the Mexican-American population was less knowledgeable concerning the impact, nature and control of cardiovascular diseases than the Anglo population with which it is generally combined. For example, only 13.9 percent of the Mexican-American, versus 22.2 percent of the Anglo respondents identified hypertension as a primary risk factor associated with heart disease. Survey results also underscored the potential role of the mass media in health education programs designed to ameliorate this problem. More than 46 percent of the Mexican-American respondents cited some form of mass media (television, radio, newspapers or magazines) as their primary source of health information, compared to 35 percent who cited their physician. Television in particular, cited by 24.1 percent, surfaced as an important channel for reaching this target population with health information. Based on these data, a six-week mass media hypertension information campaign was developed to increase awareness of, and positive behavioral response to, the problem of high blood pressure among the Spanish community in Houston. A standardized health education program methodology was employed to guide campaign design, implementation and evaluation. This methodology involved definition of objectives or anticipated program outcomes; determination of salient audience characteristics, both cognitive and motivational; delineation ability; demonstration of the need for action; inclusion of instructions for action; and reinforcement of both learning and action. Input from mass media consultants and Spanish-speaking focus groups was instrumental in the design and production of three television public service announcements in Spanish, as well as an accompanying bilingual brochure focusing on the detection and control of high blood pressure. This methodological approach proved to be an effective mechanism for developing target-specific media and messages to reach the Spanish heritage community in Houston.

Vicky Reyes

USC Cancer Center Porta-Pap Clinic project

Initiated in 1967 with federal funding, this project enabled hospitals to provide free Pap smears to disadvantaged women in Los Angeles County. Because few women availed themselves of this service, however, the directors of UCLA and Harbor General hospitals created the "Porta-Pap Clinic," a mobile facility that provides cancer education, examinations and the tools necessary to carry out the program. The project is currently based at the Los Angeles County/University of Southern California Medical Center and is funded by the Earl Carroll Cancer Clinic and the National Cancer Institute.

Miguela Rivera, M.A.

The delivery of mental health services to the Latino community: a systematic approach

An important issue in the delivery of mental health services to communities nationally has been the underutilization of existing facilities by the Latino population. While some areas have reported representative numbers using mental health facilities, the figures show a drastic decrease in the rate of individuals returning for further treatment or other assistance. Difficulties are seen, then, at various stages in the mental health services process. This research entailed an investigation of the mental health services delivery process to the Spanish-speaking population. The author then developed a systematic model of the process which provides a research framework to be used in future mental health service delivery research. This approach also delineates points of possible intervention and change in the mental health service delivery systems which may enhance the utilization of these services by the Latino population.

Zoila R. Ruiz, Ph.D.

A survey of high school bilingual students in the city of New Orleans

A survey of high school bilingual Spanish-speaking adolescents was administered in the city of New Orleans. Of the 80 students surveyed, 62% were from Central America, 32% from Cuba, and the rest from Mexico, Colombia and Puerto Rico. The purposes of the survey were to collect data regarding adolescents' family and language characteristics, books read, value systems (things liked and disliked in the Spanish-speaking culture and in the American culture), self-opinion about their knowledge of English and Spanish, adaptation to this country, etc., to find critical variables predictive of misbehavior and underachievement, to design group discussion based on these critical variables, and to disseminate the findings to teachers and school authorities. The findings indicated that family and language characteris-

tics are related not only to school grades but to difficulties at home. The mother's difficulty with English (struggling to speak in a foreign language) was related to low grades in English, Spanish and behavior. The father's knowledge of English was related to family attitudes when Spanish was not spoken at home. There was little difference between types of books read in English and Spanish. The thing most liked in the Spanish culture was family affection and sense of mutual help, and in the American culture, the proficiency of the American prototype. The most disliked thing in the Spanish-speaking culture was lack of women's rights, and in the American culture, prejudice, drugs, and corruption in youth. Subjective sense of adaptation to this country was related to self-opinion about knowledge of English and not to actual school grades. English grades were lower than student expectations. It was recommended that efforts be made to teach English to the parents and to implement a clear feed-back grading system for English in the schools.

Ruth Zambrana, Ph.D.

Research dilemmas: new directions and priorities for the Puerto Rican community

This paper attempted to assess the relationship between health services research and the delivery of health services to Hispanics, with a particular focus on the urban Puerto Rican. Specifically, it addressed research dilemmas, such as: scarcity of data; inappropriate methodological designs and approaches; and fragmentation of existing knowledge. The author reviewed the research literature and summarized observations and experiences concerning health related programs as well as the findings of a relevant and recent Delphi study. The discussion stressed research priorities and the importance of a systematic and institutionalized mechanism to conduct research which would include constituency participation. The conclusion attempted to identify factors that must be taken into account when conducting research with an Hispanic population.

Closing remarks

Ruth Hanft
Deputy Assistant Secretary for Health Research, Statistics, and Technology

I'm neither going to be optimistic nor pessimistic, but I hope somewhat realistic. Before I tell you about my own office and some more about options in the Public Health Service, I would like to make a comment on one of the things a previous speaker said. It is highly unlikely that the federal government will return to supporting investigators rather than research proposals. This is true for a number of reasons. The Congress, very clearly, wants research in priority areas that they feel are important nationally. There was a time when institutions were given support generically for research, and there was great dismay over the products of that research. They were highly scattered, they were of variable quality, and there were no competitive incentives. I think it highly unlikely that the federal government will go in that direction, even though the MacArthur Foundation might do it. I do believe that we have to have some mechanism to support researchers so that they don't live from hand-to-mouth. We have not yet found the mechanism that combines the need to address research priorities with the need to keep a core of researchers together, but I do not see that alternative developing in the near future.

Let me first talk about my own office's commitment. As you heard throughout this conference, this is a conference sponsored by one of the components of my office. It had my office's 100 percent backing and, to some extent, stimulus. We very much want to develop an Hispanic health research initiative. That, however, cannot move very quickly because we have to set priorities, and we really have to develop a firm agenda that we can stand on. But we are committed. Our commitment also shows through some of the activities of the National Center for Health Statistics. HANES III, which is directed specifically at Hispanic Americans, is in the planning stage; the funds are allocated; we plan to move ahead with this survey, and the suggestions we got at a meeting on HANES III during this conference were extremely helpful. As you also know, we have now added the Hispanic category to all of our surveys, which means that in the future, the Health Interview Survey and the Family Growth Survey will be producing data on Hispanics to fill those gaps we talked about throughout the conference.

NCHSR does want to develop a research agenda, but in the interim, there are ways of funding Hispanic research through the other priorities of the National Center for Health Services Research. For example, when we put out a grant solicitation on planning and regulation, there is no reason why someone could not come in with a good grant directed at planning and regulation in a predominately Hispanic area, or if we come out with a research solicitation on maternal and child health, a grant proposal can come in specifically addressed to problems of Hispanic children. So even without a fully-fleshed-out Hispanic research agenda, it is possible right now, within our research priorities, to direct some of the research toward Hispanic interests and problems. Gerry, I know, will go much further into these possibilities.

We also provide dissertation support. They are small grants, but a graduate student who is interested in doing his or her dissertation in the Hispanic area can apply for a dissertation grant. If it is approved through peer review, there is a good likelihood that he can get the grant.

Let me move from the National Center for Health Services Research to the rest of the Public Health Service, and a little bit to the Health Care Financing Administration. There are research funds in literally every agency of the Public Health Service. In the solicitations within those programs, there are subinterests in Hispanic problems and Hispanic issues. For example, the Health Services Administration has a research grant program in maternal and child health. I would guess that a number of people

in this audience have had some support through that source. So does the National Institute of Child Health and Human Development. There is more than one place to look for research funds. The Alcoholism, Drug Abuse, and Mental Health Administration (ADAMHA) has a large research grant program. The Community Health Center programs have some research funds. The Emergency Medical Services Program has some research funds. I could go down the list of virtually every component. CDC has some research funds in areas of interest to the Center for Disease Control.

I would make one point, however, about all of the Public Health Service grants, and particularly those of the National Center for Health Services Research. These are competitive grants. They, by and large, are reviewed by outside peer review groups, and this is done by law in most of the Public Health Service agencies. This means that the research proposal must be a quality proposal. So, the idea can be brilliant, but if the methodology is not developed and if it isn't a good research proposal, the peer review groups will probably not approve it. As was said before, not everything that is approved is funded. That depends on the fluctuations in funds—and they do fluctuate—and the priorities. You have to watch the funds year to year as they swing from agency to agency, and you have to trace the swing. In some years, the National Institute of Child Health will have a considerable amount of new money; in another year, it may be the National Institute for Aging or the National Center for Health Services Research.

Finally, if it is a Medicare-Medicaid specific research proposal, you can apply to the Health Care Financing Administration. Although their budget looks very large for research, it is not large in real research. They focus on large demonstrations like rate regulation, but they do have some research money in Medicare and Medicaid, and that is another resource that you should watch very closely because that also fluctuates from year to year.

I would say something about priorities in developing your agenda. We are not, in the near future, going to be able to fund every issue in Hispanic health services research. It would be very helpful to us if tomorrow when you review the reports of all of the task forces, you try to indicate what are the priorities and what are the trade-offs. For example, if you want to put a lot of money into an institute, that probably would mean there would be few resources for specific research proposals. A research agenda is not necessarily a research agenda for one year; it can be a research agenda that flows over a period of years, and I am therefore suggesting that you look very hard at what you think are the first and most important issues. We want to work with you. This is a very important area to us, and I see this as something that is going to evolve over time although the start might seem, at first, to be relatively modest.

Closing remarks *(cont.)*

Dorothy Rice
Director, National Center for
Health Statistics

I want to leave one message with all of you. NCHS, the National Center for Health Statistics, is committed to improving the data base on the health of Hispanics in the United States. This has been part of our mission, it is part of our mission, and it will be part of our mission in the future. We have undertaken quite a few new activities, the biggest one being the new Health and Nutrition Examination Survey of Hispanics. We are very pleased to have had the opportunity to meet some of you this morning to discuss how we can improve the design and implementation of this important survey that will be a gold mine of information for all of us in the future.

We don't have a grant program in NCHS. We have authority, but no funds. Nevertheless, I do want to remind you that the HANES Hispanic program will cost approximately $10–12 million. Many people don't realize the cost of a national survey of this kind, not only in personnel, but in dollars in going out and interviewing and examining the individuals. The findings will become a resource that I hope many of you will use in the future. Indeed, I hope that many of you will encourage your students to use that information as a data base for their dissertations.

The National Center for Health Statistics is supported by public funds. All the information that we collect becomes public property with, of course, safeguards for the privacy and confidentiality of the individuals who provided the information. We offer public-use data tapes to those who would like to do special and detailed analysis. With the information now becoming available on Hispanics from all of our surveys, the tapes should provide a considerable resource that I hope all of you will recognize and use in the future. One of our low-keyed activities is a clearinghouse on health status indexes. If you want more information about this, please don't hesitate to ask any of us from NCHS. I know that the computer run does have race and ethnicity as one cut. It also includes all published information that we can get our hands on as well as the summaries of ongoing research activities that we become aware of. The clearinghouse is a very good source of information for anyone who would like to do work in this area.

We have a commitment to integrate information about Hispanics in all of our data systems, and I think that you will see the results of this in the future. As I have said before, NCHS has been designated as the source of information on health of Hispanics as part of the DHHS initiative on Hispanics that you are going to be hearing more about. I promise to send all of you who have requested it the information that we now have available and to put you on a mailing list for future reports. I have also included a mailing list request form. You can check off the information you would like to have, and these will be sent to you free of charge. With few exceptions, single copies of all publications are available without charge upon request. I know when I offer these resources to you, we will be inundated with requests, but we are pleased to provide the information if we have it. We also answer special requests within the limitation of resources that we have. I do want you to know that we are available to respond to your questions. Too often people say, "We don't have the information—I know there is nothing like it available." But if you look a little further, there is probably something that might help in your research activities in the future. I do thank you for the opportunity to meet many of you for the first time and to solicit from you the assistance that we need to carry on our programs.

Closing remarks *(cont.)*

Gerald Rosenthal, Ph.D.
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Everything of substance has probably been said, and it's difficult to compete with the sunshine and the waning day, but I would like to make a few comments on several issues that I think are important.

New money is a concept that only means things in Washington. The fact is that many budgets change a great deal, but resources do not necessarily go to precisely the same place every year. Any resources of large consequence that are targeted to issues related to the Hispanic population are going to mean new money for this purpose no matter where it comes from. Budgets may stay the same, but how they are used changes all the time. This is true for almost all federal programs; it is true for the foundations, and it is true for local sources of funding.

A good idea does not necessarily make a good research project. We get a lot of dynamite ideas all the time but they are unfortunately part of an inferior research proposal. They are not all produced by people without experience or competence or without track records of successful research projects. It is a lot harder to address in a systematic, responsible, unambiguous way the component of an important question through research, data acquisition, or analytic strategy than it is to pose an important problem that gets to be studied. The essential nature of good research is to structure the question so that it is germane to the general problem and can be addressed by the data that are available. It is here that research methodology enters the picture. In making the kinds of compromises that must be made, a lot of baby gets thrown out with the bath water. A lot of times what you finally examine in the course of a project is not precisely the same as the critical question you hoped to resolve. That is unfortunate, but we live in a complicated world and some things that are really important cannot be addressed through research. A good title does not make a good piece of research, but often a good subject can be examined with the right methodology and some technical help. We view our role in this area as one of critical importance.

NCHSR is basically concerned with the nature of the question being examined and the methods that will be employed to study the problem. These matters determine how the NCHSR research funds are employed. Prior research, reputation, or status in the field do not govern the decisions. The question of obtaining support for research is largely dependent upon the proposal provided by the investigator. I suggest therefore that you think about what you want to know, think about what you can do analytically, and come to us for whatever help you may need. Let us assess your proposal. Our scrutiny does not guarantee funding, but it does serve a useful purpose. In effect, it permits you to share your problems and your ideas with your colleagues.

It is important that there is a separate category in this year's research priorities called Hispanic problems, but one should not lose sight of the fact that the kinds of issues raised under this rubric appear in every priority that has been articulated. There is a potential Hispanic focus in much of the research that we do. The emphasis on Hispanic matters *per se* needs to be addressed by the people in this room, as well as the rest of the research community. In principle, NCHSR is interested in virtually everything involving the delivery of health services. The law is very broad in its mandate. Within virtually every one of the categories defined in the statute, you could address problems specifically related to one or another group in our population. For example, one could link Hispanic research to questions of cost containment or health manpower. It is therefore useful for you to consider not only your own goals when you seek to define a research project but to look at the general concerns in the areas of health

services and the general research priorities that have been identified.

Unlike the situation some years ago, NCHSR, as well as other research organizations, has been much more responsible and forthcoming about telling people what we are interested in supporting. We cannot fund anywhere near the amount of research that is viewed as technically meritorious. More proposals are approved than we could possibly fund. But those that get funded are the ones that are targeted on general priorities—proposals that we think are most likely to yield a fruitful result not only with regard to their particular focus but also with regard to resolving general questions or providing general information on problems in the delivery of health services.

NCHSR is not a box into which you drop a research application and out of which come funds to support research. The business is much more methodical. The identification and relation of research to priorities is carefully considered. We begin with the concerns of user communities in this country and end by trying to give them the information they need to resolve their problems. These are the basic components of our enterprise, and we believe that this approach is crucial to the success of our research.

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(HRA) 76-3144 Evaluation of a Medical Information System in a Community Hospital (PB 264 353, available NTIS only)

(HRA) 76-3145 Computer-Stored Ambulatory Record (COSTAR)(PB 268 342)

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16. Abstracts

This report contains the proceedings of the first Hispanic Health Services Research Conference, which was supported by a grant from the National Center for Health Services Research with additional funding from the Veterans Administration. The conference addressed the health problems of Hispanic populations in the U.S., identified needed areas of research, and recommended methodologies appropriate for conducting health research among Hispanic populations. The recommendations of the conference are presented in the individual reports of the four task forces, which focused on: the impact of national, regional, state and local health policies on health services for Hispanics; sociocultural influences and health services delivery for Hispanics; resource development strategies for conducting health services research among Hispanic populations; and facilitation of the timely dissemination and assessment of Hispanic health services research.

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